

# HEALTH CARE CHALLENGES FACING NORTH CAROLINA'S WORKERS AND JOB CREATORS

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## FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,  
EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION  
AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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HEARING HELD IN CONDORD, NC, APRIL 30, 2013

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## **HEALTH CARE CHALLENGES FACING NORTH CAROLINA'S WORKERS AND JOB CREATORS**

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**Tuesday, April 30, 2013**  
**U.S. House of Representatives**  
**Subcommittee on Health, Employment, Labor, and Pensions**  
**Committee on Education and the Workforce**  
**Washington, DC**

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The subcommittee met, pursuant to call, at 9:00 a.m., in room 106, Building 1000, Rowan Cabarrus Community College, 1531 Trinity Church Rd., Concord, NC, Hon. David P. Roe, [chairman of the subcommittee] presiding.

Present: Representatives Roe and Hudson.

Staff Present: Casey Buboltz, Coalitions and Member Services Coordinator; Benjamin Hoog, Legislative Assistant; Brian Newell, Deputy Communications Director; Todd Spangler, Senior Health Policy Advisor; John D'Elia, Minority Labor Policy Associate

Chairman ROE. A quorum being present, the Subcommittee on Health, Employment, Labor and Pensions will come to order.

Good morning, everyone. First, let me take a moment to thank our witnesses for joining us. We know you all are very busy, and we appreciate the opportunity to hear your thoughts on the very important issue of health care. Second, I would like to thank the people of Concord, North Carolina and the community college staff for their hospitality.

The Herald-Sun recently reported on a job fair organized by the North Carolina Technology Association. Dozens of local companies attended the job fair, which was visited by people like Bernita Nichols. For the first time in 28 years, Ms. Nichols is looking for work after her employer went out of business. She described the labor market as "tight merely because of the number of people who are looking." Richard Corridore also attended the job fair and noted, "The job market is not recovered; it's still very difficult."

These remarks underscore the job crisis we continue to face. Nearly 12 million Americans are unemployed. Approximately 4.6 million have been out of work for six months or longer. The number of men and women in the labor force is at its lowest level in 35 years, indicating more people are giving up their search for work in this dismal job market.

Though officials claim the recession ended almost four years ago, countless families and small business owners find that hard to believe. No doubt, many in the Tar Heel State feel the same way when roughly 1 out of every 10 workers in the state is unemployed.

As policymakers, we have an obligation to make job creation our number one priority. Ending wasteful government spending, opposing unnecessary regulations, preserving the safety net for seniors and vulnerable families, and moving toward a balanced Federal budget are all part of an effort to get this economy moving and help put people back to work. Today's hearing is a small but important part of that effort.

We can't talk about jobs and the workforce without discussing health care. Approximately 160 million Americans receive health care coverage through an employer. They and their families know all too well the challenge of rising health care costs, which can result in more than loss of coverage; it can also lead to lower wages and fewer jobs. That is why it is absolutely vital we put in place reforms that will bring down costs and expand access to affordable care.

However, President Obama and his allies in Congress took our nation in an entirely different direction. Despite significant opposition from the American people, the President signed into law a government takeover of health care that is wreaking havoc on our workplaces. Instead of responsible solutions to strengthen our health care system, we have empty promises that have made a broken system even worse.

For example, we were promised if we liked our current health care plan, we could keep it. But according to the Obama Administration's own estimates, millions of individuals will experience significant changes to their health care plan.

We were promised the law would create 4 million jobs. Yet barely a week goes by that we don't learn of employers who might be forced to reduce their work hours or cut the size of their workforce due to the law's punitive mandates and tax increases.

The President also promised his plan would reduce insurance premiums by \$2,500. Instead, the premiums for the average family increased 4 percent last year and 11 percent the year before. Estimates suggest they will continue to rise in the years to come.

Over the next decade, the law is expected to hit certain employers with \$117 billion in higher taxes for failing to provide government-approved health insurance; levy \$55 billion in new taxes on individuals who don't purchase government-approved health insurance; and cost taxpayers close to \$2 trillion in new spending. It is no wonder proponents of the law are beginning to question whether this law is sustainable.

This flawed law is simply not in the best interest of workers, employers, and families. However, Obamacare is the law of the land and we have to examine how it is affecting our families and workplaces. I want to thank our witnesses again for sharing their perspectives and their ideas for responsible reforms that will better address our health care challenges.

Just to let you know, as Chairman of the Health, Employment, Labor Subcommittee, I am your next-door neighbor over in Tennessee, in the mountains of East Tennessee, and my district goes from Mountain City to Gatlinburg. So I border a lot of North Carolina, and I feel like as many times as I fly through Charlotte, I should have a zip code or an address here.

I spent 31 years practicing medicine. I was an Ob/Gyn doctor in a group there. They started with four doctors, and we have grown that to 100 doctors, and now with 450 employees. So I spent my entire life as a physician practicing medicine. The problem with the American health care system is it costs too much, it is too expensive. Two, we had groups of people who didn't have access to affordable coverage. That was the problem. Thirdly, we had a liability crisis. And basically this health care plan did increase access by increasing the number of Medicaid patients, which is already a system that hasn't worked very well, and taking a lot of money out of Medicare, a system that is already in financial crisis.

So that is why I am here. I have only been in Congress four years, and Richard, my friend here, Richard Hudson, has only been there for less than a year. So we are not career politicians. We are people that are trying to help solve problems of this country.

I will now, without objection, I would like to yield to my good friend, Richard Hudson, for any opening remarks he would like to make.

[The statement of Chairman Roe follows:]

**Prepared Statement of Hon. David P. Roe, Chairman,  
Subcommittee on Health, Employment, Labor and Pensions**

Good morning everyone. First, allow me to take a moment to thank our witnesses for joining us. We know you all are very busy, and we appreciate the opportunity to hear your thoughts on the very important issue of health care. Second, I would like to thank the people of Concord, North Carolina and the community college staff for their hospitality.

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This flawed law is simply not in the best interest of workers, employers, and families. However, ObamaCare is the law of the land and we have to examine how it is affecting our families and workplaces. I want to thank our witnesses again for sharing their perspectives and their ideas for responsible reforms that will better address our health care challenges.

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Mr. HUDSON. Thank you, Chairman Roe. On behalf of the people of Concord and of this district, please allow me to extend a warm welcome and offer my sincere appreciation to you for holding this hearing here today. I am particularly thankful also for Rowan Cabarrus Community College. The president, Dr. Carol Spalding, is here with us. Thank you for allowing us to host this hearing here on our campus. It says "their campus," but I am saying "our campus" because I served on the Board of Trustees here from 2002 to 2005 and I understand how important this community college is to our local community and how critical this college is and the colleges across North Carolina are to creating jobs and growing the businesses that we have here.

To our witnesses, thank you for taking your time from your very busy schedules to be here with us today. It is important that this committee understand the real implications that the Affordable Care Act will have on jobs and on the industries you represent.

North Carolinians are hard-working individuals who are extremely concerned with the ever-increasing role government plays in our daily lives. North Carolina currently has the fifth highest unemployment in the country. Some counties in my district have between 12 and 16 percent unemployment, and that is the reported unemployment. I tell folks all the time when they ask what are my top three priorities, they are jobs, jobs, and jobs. And so that continues to be my focus. Our priority as a state and a nation should not be implementing more mandates handed down by Washington, but doing all we can to roll back the regulations that are crushing small businesses and enable our employers to get back to creating jobs and hiring people.

The problems facing America's economy and workforce are immense, and the current regulatory environment simply creates confusion, anxiety, and a culture of uncertainty among small businesses. The extremely detailed and complex regulations that make up the Affordable Care Act only add to the hesitation businesses have with hiring people in a climate that is already clouded with regulations. The U.S. Chamber of Commerce recently conducted a



survey of small business owners in which 71 percent of the participants in the survey said that it will be harder to hire new people under the current health care law.

I was recently talking to a business owner who owns a few oil change franchises, Quick Lube kind of places, and he told me that he bought land to build three new businesses, but he wasn't going to do it. When I asked him why, he said because it will add about 15 new employees, and that will put him over 50 employees total, which would make the Affordable Care Act apply to him. While 15 jobs isn't enough to turn this whole economy around, I sincerely believe that we are going to turn this economy around 15 jobs at a time, or 5 jobs at a time, or a couple of jobs here and a couple of jobs there as business people take risks and hire and expand their business.

Some of the original leading proponents of the Affordable Care Act are starting to vocalize just how detrimental the effects of this law will be. Democratic Senator Jay Rockefeller recently stated, "I am of the belief that the Affordable Care Act is probably the most complex piece of legislation ever passed by the United States Congress," and he has been there a while, so he has seen a lot of legislation. "It's just beyond comprehension," he concluded. Senate Democrat Max Baucus, who helped write the legislation, just a couple of weeks ago said, addressing the implementation of the law, said, "I just see a huge train wreck coming down." Well, business people across this district have been telling me for a year now about this train wreck, but even the folks who wrote the law are starting to see it.

I was not a member of Congress when the Affordable Care Act was passed into law. However, from the beginning, I joined the public debate in opposition to this government takeover of health care. Since being sworn in, I have taken numerous steps to stop or at least try and fix this dangerous health care law that will harm our job creators and workers if left in place. I recently co-sponsored legislation to repeal and defund the law entirely and have introduced legislation that takes an incremental approach to chip away at harmful provisions within the law.

I know that good ideas don't originate in Washington, D.C. Therefore, it is important that we hear from real people out here in the real world. That is why I live in Concord and commute to Washington every week to vote, but I come home every weekend. That is also why I was grateful to learn that the subcommittee was willing to convene this field hearing here today. The way I talk about it, I fly to Washington every week and take common sense with me. But this is an opportunity to bring Washington to the common sense. And so we are very thankful to have this today.

Today's hearing serves as an opportunity to examine the real-life effects of the Affordable Care Act's implementation and I am looking forward to an open discussion about how we can work toward common-sense solutions that help expand access to affordable care for the American people.

I would yield back, Mr. Chairman.

[The statement of Mr. Hudson follows:]

**Prepared Statement of Hon. Richard Hudson, a Representative in  
Congress From the State of North Carolina**

Thank you, Chairman Roe. On behalf of the people of Concord, please allow me to extend a warm welcome and offer my sincere appreciation for convening this hearing today. I am particularly thankful for Rowan Cabarrus Community College allowing us to host this hearing on their campus. I served on the Board of Trustees at this college from 2002-2005 and I know what an integral part of the community it is.

To our witnesses, thank you for taking the time out of your busy schedules to be here today. It is important that this committee understand the real implications that the Affordable Care Act will have on job creators like you.

North Carolinians are hardworking individuals who are extremely concerned with the ever-increasing role government plays in our daily lives. North Carolina currently has the fifth highest unemployment rate in the country—some counties in my district have between 12 percent and 16 percent unemployment. I tell folks all the time my top three priorities are JOBS, JOBS, and JOBS. Our priority as a state and nation should not be implementing more mandates handed down from Washington, but doing all we can to roll back the regulations that are crushing small business and enable our employers to get back to creating jobs.

The problems facing America's economy and workforce are immense, and the current regulatory environment simply creates confusion, anxiety, and a culture of uncertainty among small businesses. The extremely detailed and complex regulations that make up the Affordable Care Act only add to the hesitation businesses have with hiring people in a climate clouded with regulations. The U.S. Chamber of Commerce recently conducted a survey of small business owners in which 71 percent of the participants in the survey said that it will be harder to hire new employees under this health care law.

I was recently talking to a business owner who owns a few oil change franchises and he told me that he bought land to build 3 more shops, but isn't going to build them now. I asked why and he said because it will add about 15 new employees, which will put him over the 50 employee threshold. While we may not be able to turn the economy around with 15 jobs, we can turn it around 15 jobs at a time. Our government shouldn't be penalizing businesses who want to expand, they should be encouraging it. Unfortunately, this is the reality under the President's health care law.

Some of the original leading proponents of the Affordable Care Act are starting to vocalize just how detrimental the effects of the law will be. Democratic Senator Jay Rockefeller recently stated, "I am of the belief that the Affordable Care Act is probably the most complex piece of legislation ever passed by the United States Congress. \* \* \* It's just beyond comprehension." Senate Democrat Max Baucus, who helped write the legislation, recently addressed the implementation of the law saying, "I just see a huge train wreck coming down."

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I know that good ideas don't originate in Washington, D.C. Therefore, it is important that we hear from real people out here in the real world. That's why I live here in Concord and commute to Washington to vote. That's also why I was grateful to learn the subcommittee was going to convene this field hearing here today. Today's hearing serves as opportunity to examine the real life effects of the Affordable Care Act's implementation and I'm looking forward to an open discussion about how we can work toward commonsense solutions that help expand access to affordable health care for the American people.

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Chairman ROE. I thank the gentleman for yielding.

Pursuant to committee Rule 7(c), all members will be permitted to submit written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

We have two distinguished panels of witnesses today, and I would like to recognize Mr. Hudson to introduce our first panel.

Mr. HUDSON. Thank you, Mr. Chairman. It is my pleasure to introduce our first panel.

First we have Mr. Chuck Horne, who is the President of Hornwood, Inc. in Lilesville, North Carolina. Hornwood, Inc. manufactures various textiles, including the fabric used in our infantry's combat boots. Mr. Horne holds a Bachelor's of Science in Textile Technology and has been named a distinguished alumnus of NC State University.

Ms. Tina Haynes is the Chief Human Resource Officer at Rowan Cabarrus Community College in Salisbury. Before her current position at Rowan Cabarrus, Ms. Haynes was an Operations Manager at Humana Health Plans and Senior Vice President of Wachovia Financial's Human Resources Division.

Mr. Adam Searing is the Director of the Health Access Coalition in Raleigh. He has been named by President Obama as a Champion of Change. He holds a Juris Doctorate from UNC Chapel Hill.

And Mr. Ken Conrad is Chairman of Libby Hill Seafood Restaurants in Greensboro. Mr. Conrad began as a cook in his parents' restaurant, eventually becoming company president in 1983. He is Vice Chair of the National Restaurant Association in Washington, D.C.

Thank you all for being here.

Chairman ROE. Before I recognize your testimony, let me briefly explain our lighting system. We talked about this before. You have five minutes to present your testimony. When you begin, the light in front of you will turn green. When one minute is left, the light will turn yellow. When your time has expired, the light will turn red, at which point I will ask you to wrap up your remarks as best you can. After you have testified, members will each have five minutes to ask questions, and as I mentioned previously, we probably will have two rounds of questioning.

Mr. Horne, we will begin with you.

**STATEMENT OF CHUCK HORNE, PRESIDENT,  
HORNWOOD, INC., LILESVILLE, NC**

Mr. HORNE. Thank you, and good morning.

Chairman ROE. Did you push the "On" button?

Mr. HORNE. Yes, I did.

Chairman ROE. Pull the mic a little bit closer.

Mr. HORNE. A little closer?

My name is Chuck Horne, and I am a resident of Anson County, North Carolina. I am President of Hornwood, Incorporated, a family-owned textile business that has been in operation since 1946. I am second generation in the business and proud to say I have a son working with me that will be able to carry the business forward for another generation. We are the largest private employer in Anson County, with 350 employees which we call partners. Our business has managed to grow and prosper over the last 66 years because of the dedication of our partners. We are proud of our accomplishments, particularly in view of the devastating impact imports have had on the textile industry in the last 12 years.

Our company is self-insured and provides one of the best medical, dental and vision plans in the area. Hornwood pays 80 percent of the cost, and our partners pay the other 20 percent through weekly premiums. In 2012 the company's expense for health care, above the premiums collected, was in excess of \$2.5 million, approximately 5 percent of our revenue. We have a company nurse that works with our partners to promote healthy lifestyles in terms of diet and exercise, and she also works with them to get preventive services such as colonoscopies and mammograms which are provided at no cost to the partner. We have an on-site exercise facility and provide a free annual health screening in partnership with our local hospital.

We don't do this because we are forced to by any agency, but because it is the right thing to do. The health and well-being of our partners is an important part of controlling our costs and remaining competitive. When the Affordable Care Act was passed, I did not express much concern because I knew we offered a plan that far exceeded the mandates imposed on an employer our size. As time went by, we began to learn that we were going to have to pay more, but not for the benefit of our partners. For example, in 2014, we will have to pay \$63 per covered individual to help pay for the adverse selection that will hit the insurance exchanges. The amount we pay will exceed \$32,000. This provision continues through 2016.

Like many private employers, we are a Subchapter S corporation, and as such the income of the company flows through me, which results in an income in excess of \$250,000. As a result of the Affordable Care Act, I will have to pay an additional nine-tenths of a percent in Medicare taxes and an additional 3.8 percent tax on investment income starting this year. This will result in more money being taken from the company, money that could have been invested in new equipment or training for our partners to help keep us competitive.

One of our frustrations with the Affordable Care Act is the lack of knowledge we and our health care advisors have with the law. Aside from the additional expense, it places an administrative burden on us to try and comply with the provisions. It is difficult to get definitive answers to our questions. Our human resources department has spent countless hours trying to understand the law.

I thank you for your time and your service and will do my best to answer any questions.

[The statement of Mr. Horne follows:]

**Prepared Statement of Chuck Horne, President, Hornwood, Inc.**

Good morning. My name is Chuck Horne and I am a resident of Anson County, NC. I am the president of Hornwood, Inc., a family owned textile business that has been in operation since 1946. I am second generation in the business and proud to say I have a son working with me that will be able to carry the business forward for another generation. We are the largest private employer in Anson County with 350 employees which we call partners. Our business has managed to grow and prosper over the last 66 years because of the dedication of our partners. We are proud of our accomplishments, particularly in view of the devastating impact imports have had on the textile industry over the last 12 years.

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Chairman ROE. Thank you, Mr. Horne.  
Ms. Haynes?

**STATEMENT OF TINA HAYNES, CHIEF HUMAN RESOURCE OFFICER, ROWAN-CABARRUS COMMUNITY COLLEGE, SALISBURY, NC**

Ms. HAYNES. Thank you. I would like to thank you for the opportunity to testify today about the Affordable Health Care Act and its impact on the Rowan Cabarrus Community College. Considered a large employer under the definition of the Affordable Care Act, Rowan Cabarrus College has focused on emerging regulations, and we are alarmed at the extent to which regulations will affect our college. As currently published, the supporting regulatory framework has far-reaching and significant negative consequences. The regulations defining how benefits eligibility works will force us to reduce the number of courses we currently allow adjunct faculty members to teach, produce a costly and significant administrative burden, and potentially result in penalties.

Further, it effectively reduces the income that dedicated adjunct faculty will be able to earn at Rowan Cabarrus, and it may slow our students' ability to get degrees if we drop courses from the schedule.

As a strategy for responding to the variability in course demand and controlling costs while maintaining high-quality instruction, Rowan Cabarrus relies on adjunct faculty. Like our sister institutions, we operate with a lean budget, remaining responsive to unexpected funding cuts and variability in demand that is driven by external forces such as high unemployment.

The use of adjunct faculty is the best approach to augment full-time faculty without introducing an unsustainable cost for more full-time employees.

In December of 2012, the IRS stated specifically that it is unreasonable to only consider the time spent in instruction toward benefits eligibility. Because of this change, our institution will have to reduce the hours that adjunct faculty can teach. A ratio of 3 hours of service time for every 1 credit hour of instruction was suggested by the IRS. While the Internal Revenue Service is still taking comments, it is unclear whether anything less than the 3-to-1 ratio will be acceptable.

Underlying the IRS regulation is an inconsistent approach between the Department of Labor and the IRS. According to Department of Labor standards, faculty are exempt employees, and they are paid on the basis of instructional hours. They may work more hours at their discretion, like others who are classified professionals. Now the IRS has explicitly stated the hours outside of instruction time should be counted toward benefits eligibility, which is fundamentally different than the Department of Labor's instruction on exempt employees.

While it is true that the Department of Labor is defining compensable hours, and the IRS is defining benefits eligibility hours, it seems plausible that the basis for both would be the same.

Further, the regulations that should result in greater access to affordable health care ultimately work against adjunct faculty. Dedicated adjunct faculty who have had steady, multi-course workloads for years will lose income and have less money to purchase coverage through those health care exchanges.

This impact ultimately reaches our students. Rowan Cabarrus must consider reducing courses offered, and if students can't get the courses they need, they can't complete their degrees and can't become employable. It is a financial impact to them, and it is a burden on the economic engine of our community since these students can't contribute to the tax base, and they can't become consumers of goods either.

To administer the new regulations, our institution will incur one-time and recurring costs to determine eligibility, notification, enrollment, and there will be new billing, remittance and collections processes for health care coverage for former employees. When applying all the rules, the variation in employee populations and different measurement periods are complex, and as a population adjunct faculty may work one semester and then may skip the next. Employees who don't work for us currently but worked for us during the prior measurement period are still qualified to participate in our health plan during the next stability period, but we can't deduct for insurance premiums because they are no longer on our payroll. So that sets us up for collections and expenses if it is uncollected.

In addition to complex rules and measurement, the regulations assess penalties for excluding employees from eligibility. Even with the 5 percent margin of error that is provided by the regulations, a single systematic error could inadvertently exclude individuals from coverage and result in disastrous and crippling penalties.

Like our sister institutions, we must reevaluate course schedules, and we are acutely aware that our students will be affected when courses are eliminated from the schedule. We ask for your support for us and for other public institutions that can't shut down registration, and we can't limit the number of freshmen coming in for the next semester as a means to control our benefits costs. We need the flexibility to develop and apply rules that, while consistent in approach to providing health care eligibility, provide the flexibility that respects the unique and varied nature of courses being taught.

Again, I thank you for the opportunity to present the impact of the Affordable Care regulations on our institution. We are hopeful that our remarks today highlight the very real impact of these regulations on our institution, our employees, our community, and our sister institutions across the nation. Thank you.

[The statement of Ms. Haynes follows:]

**Prepared Statement of Tina M. Haynes, MS, SPHR,  
Chief Human Resources Officer, Rowan-Cabarrus Community College**

I would like to thank you for the opportunity to testify about the impact of the Affordable Health Care Act on Rowan-Cabarrus Community College. Considered a large employer under the definition of the Affordable Health Care Act, Rowan-Cabarrus Community College has focused on emerging regulations and guidance, and we are alarmed at the extent to which this act will affect the college and its workforce. As currently published, the supporting regulatory framework has far-reaching and significant negative consequences for the college and our employees, our students, and our community. The regulations defining how health care coverage eligibility works will force us to reduce the number of courses we currently allow adjunct faculty members to teach, produce a significant and costly administrative burden and could further harm the institution through egregious penalties if errors are made in identification of those who qualify for health care coverage. Further, it effectively reduces the income that our long-time, dedicated adjunct faculty will be able to earn, and it may slow our students' ability to get degrees if we must eliminate courses from the academic schedule.

*IRS guidelines will force the reduction in courses adjunct faculty can teach*

As a strategy for responding to the variability in course demand and controlling costs while maintaining high quality instruction, Rowan-Cabarrus has relied on adjunct faculty since its origin in the 1960's. Employment of adjunct faculty is the best approach for providing high quality, experienced instructors with current, real-world experience to supplement our full-time faculty without introducing an unsustainable expense of additional full-time faculty. Like our sister institutions, we operate with a lean budget; we must remain responsive to unexpected funding cuts and variability in demand that is driven from external forces such as high unemployment.

Rowan-Cabarrus Community College is certain that we will have to reduce the total hours that adjunct faculty can teach because of IRS regulatory changes related to the Affordable Health Care Act. In December of 2012, the IRS published guidance that requires us to consider more than instructional time when calculating benefits eligibility, stating specifically that it is "unreasonable to only consider the time spent in instruction". A ratio of 3 hours of service time for every one credit hour of instruction was suggested by the IRS since faculty are exempt employees by Department of Labor standards and don't require tracking for actual hours worked. Effectively, this means that an instructor cannot teach more than three, 3-credit hour courses without exceeding the 30-hour threshold for health care coverage eligibility. While the IRS is taking comments on this point, it is unclear whether anything other than the 3:1 ratio will be acceptable.

The regulations that should result in greater access to affordable health care ultimately work against the adjunct faculty. Reducing the course load for adjunct faculty is the only way that Rowan-Cabarrus can avoid the unfunded liability of additional health care cost. This further compounds the problem for adjuncts who still aren't covered by health insurance, and now, have a reduction in income because we reduced the number of hours they will be working for us.

The impact ultimately reaches our students. Rowan-Cabarrus must consider reducing courses offered if we don't have an adequate number of faculty to teach. Students can't get jobs if they can't get the courses they need to complete degrees. This

is a tremendous economic impact for them, but it is also a drag on the economic engine of our community since they can't be contributors to the tax base or consumers of goods without an income.

*The administrative burden of affordable health care*

Not only does the Affordable Health Care Act negatively affect adjunct faculty income and slow student progress toward employability, it introduces a massive administrative burden that comes with unanticipated costs. Rowan- Cabarrus will incur one-time costs to establish processes needed and will have recurring costs related to managing the workforce, determining eligibility, notification, and enrollment. There will be new billing, remittance and collections processes for health coverage for former employees who no longer work for us.

As a population, adjunct faculty may work one semester and not the next or teach multiple courses one semester and teach only one course in the next semester. Measurement periods have to address the intermittent and varied nature of their work. When applying safe harbor rules, the multiplicity of periods and the variations in employee populations are complex. Employees who don't even work for us currently, but worked for us during the measurement period, are still qualified to participate in our health plan during the next stability period but insurance premiums can't be payroll deducted since they aren't working for us. Since by state regulations we can't debit a checking account, we face collection issues and expense for premiums if not reimbursed.

*Penalties*

The Affordable Health Care Act brings a set of complex regulations and associated penalties, which if unintentionally breached, could have catastrophic results. Even with the 5% margin of error provided by regulations, a single, systematic error that inadvertently excludes individuals from coverage could result disastrous and crippling penalties.

*Summary*

Like our sister institutions, Rowan-Cabarrus must reduce the number of hours that adjunct faculty can teach. As we evaluate course schedules for the fall semester, we are acutely aware that our students will be affected when courses are eliminated from the schedule. Their employability is slowed, which in turns affects our local economic engine since they won't be earning and contributing. Dedicated, adjunct faculty who have had steady, multi- course workloads for years will lose income as their course loads are reduced. Consequently, these employees will have less disposable income to put back into our economy and less money to buy health care through health care exchanges.

Thank you again for the opportunity to present the impact of Affordable Health Care regulations on our institution. We are hopeful that our remarks today highlight the very real impact of the Affordable Health Care Act on our institution, our employees and on our community.

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Chairman ROE. Thank you, Ms. Haynes.  
Mr. Searing?

**STATEMENT OF ADAM SEARING, DIRECTOR,  
HEALTH ACCESS COALITION, RALEIGH, NC**

Mr. SEARING. Okay. Thank you very much, Mr. Chairman, Representative Hudson. I appreciate the opportunity to come and speak today. I run our healthcare work at the Health Access Coalition of the North Carolina Justice Center. We are an anti-poverty organization. We have been working to reduce poverty and expand opportunity for all North Carolinians since 1994.

Ms. Haynes, one thing that was just running through my mind when you were talking about the problems you are having with having part-time faculty, I was just looking at Governor Pat McCrory's budget and saw that he is cutting the amount of money that is coming to the community colleges, and I sure wish that he would reconsider that and give more money to our community col-



leges so they all can hire full-time faculty, because I think that would be better for everybody.

Anyway, as I said, I have had the privilege to work on this issue for a long time, and as sort of the designated hitter this morning, saying why the Affordable Care Act isn't the end of civilization, let me just go ahead and start by giving a few of the benefits that have been coming to North Carolinians since the passage of the Act in 2010. I have been hearing so much about how the sky is falling this morning that I was looking outside to see if it was actually coming down, but it is still up there.

So, for instance, I bet many folks in this room know somebody or actually have a child who is under 26 who is able to stay on their parents' health care plan now. That is a huge benefit. I have met many people in my travels around the state who have been able to keep their kids on the plan whether they are in college or not, whether they take a job, Chairman Roe, like you were talking about when the students are working in that theme park in your district and they are able to stay on their parents' plan, a great opportunity.

The other things that are happening, there is no more co-insurance co-payments for preventive services. This just makes sense. I mean, come on. If you are going to get people to come in to the doctor to get a checkup and get screened for diseases that we can treat early, it just makes sense to make that is easy as possible.

Another change. We're moving towards the situation where you can't charge women more for exactly the same health coverage that men buy. It doesn't seem right that we charge women more money for exactly the same health coverage. I am not talking about maternity care. I am talking about exactly the same health coverage. That doesn't make any sense. That is another thing that is going away with this law.

There are tax credits for small businesses that are in this law, and those are going to be expanded come 2014.

So, for over 1 million of us, however, really the biggest changes are about to come. Now, if you have health insurance already through your job, you are going to be doing all right, what these gentlemen provide here, Mr. Horne, Mr. Conrad, in their large businesses. But if you are working in a small business or you are out on your own, you are not getting your coverage through your job, you are going to be able to go to this health exchange, get a tax credit—that is the key to what Chairman Roe was talking about. You can just look on your iPad. Well, you are not going to get the tax credit to buy health insurance if you are just looking on your iPad. You have to go through this health exchange. You go through this health exchange, buy coverage if you are a business owner or working in a small business.

The other part of the change is that no longer will health insurance companies be able to charge people more because someone has a pre-existing health condition. Now, I am sure that everybody sitting up at that table up there and back here, and myself included, who has talked to anybody in the last 10 years knows somebody who has not been able to go and buy health insurance on their own, has been quoted a price of \$1,000, \$2,000 a month from North Carolina Blue Cross-Blue Shield because they had a pre-existing

health condition. Well, Blue Cross and other insurance companies are no longer going to be able to do that.

Let me tell you a story how the Affordable Care Act could make a huge difference for a business owner that I know. In Raleigh, there is a fellow who was a restaurant owner and he was a chef. His full name was Hamid Mohajer. Everybody called him Mo. He came to this country as an immigrant. He went to Campbell College when it was a college, before it became university. He had to drop out because of financial issues. He worked on a tobacco farm, Chairman Roe, and he ended up working at Darrell's in Raleigh bussing tables. He was such a good chef, though, he eventually got to go and open his own restaurant.

Well, he had a pre-existing condition, like I was talking about. He couldn't go buy health insurance. His wife went out and took a job in a chain restaurant, got some coverage. Unfortunately, he got bone cancer, ended up in the hospital. This was just devastating. What was even more devastating was that health plan was so weak and had so many limits on it that he ended up dying with hundreds and hundreds of thousands of dollars in bills. So Mo left his wife not only with a restaurant to run but also having to do fundraiser after fundraiser to pay off these medical bills that they had incurred.

Under the Affordable Care Act, it came too late for him, but he would have been able to buy coverage that took care of that. He probably would have gotten sick and, unfortunately, would have passed away anyway, but the Affordable Care Act would have made sure that he would have been able to buy a health plan for him and his business.

I hope we can go forward and think about the positive effects. Thank you very much.

[The statement of Mr. Searing follows:]

**Prepared Statement of Adam Searing, J.D., MPH,  
Health Director, North Carolina Justice Center**

Mr. Chairman, Representative Hudson, and committee members—thank you very much for the opportunity to speak today. The North Carolina Justice Center is a statewide organization created in 1994 committed to reducing poverty and expanding opportunity for all North Carolinians.

I have had the privilege to direct our health care work at the Center for the past fifteen years, and I am very excited to be a part of implementing the Affordable Care Act here in North Carolina.

Millions of North Carolinians are already seeing some benefits from the Act—like kids under 26 able to stay on their parents' health plans to freedom from copayments and coinsurance for basic preventive health services for people both on Medicare and on private coverage to a fairer marketplace where women can no longer be charged more money than men for exactly the same health coverage.

For over one million North Carolinians however—many of us owning or working in small businesses—the best is yet to come. Starting later this year, employees in businesses that choose not to provide health coverage will be able to sign up for new health plans in the health exchange. If their family income is under about \$88,000 a year, they will qualify for tax credits—and the lower your income, the higher the tax credit—that will be worth thousands of dollars and will make that insurance affordable. And business owners will be able to buy coverage in the exchange too.

In addition, business owners and employees will no longer have to worry that a pre-existing health condition will mean insurance companies will quote them unattainable monthly premiums. I cannot tell you how many people over the years I have met around our state who, because of a pre-existing health condition, have been quoted premiums of \$1,000, even \$2,000 a month! In just a few months, that will be a thing of the past.

Yes—employees will now have a place to go for coverage no matter what.

Let me tell you a story about how the Affordable Care Act will change lives.

In Raleigh the restaurant owner and influential chef Hamid Mohajer could not get health insurance due to a preexisting condition after he started his restaurant. (he attended Campbell College and worked on a tobacco farm before his successful restaurant career—Mo's Diner) His wife had to take a part-time job at a chain restaurant to get some form of coverage. In 2010 Hamid got bone cancer and needed extensive treatment. The flimsy policy offered by his wife's employer capped benefits and didn't cover everything Hamid needed. After he died his wife not only had to worry about sustaining the family's business, she had to host regular fundraisers to pay off the medical bills. That's no way to run a business or a health care system.

The changes for our business owners and employees come too late for Hamid, but will be most welcome by many of the people I meet every day across North Carolina.

Finally, let's get some things straight about the Affordable Care Act and North Carolina:

1. Any business with less than 50 full time employees—95% of the businesses in NC—has no penalties and has no requirements to meet under the ACA. None. Owners and employees of this vast majority of businesses in our state do get access to the health care exchange however along with tax credits to buy affordable coverage for many families.

2. Governor Pat McCrory's decision to follow the General Assembly and reject over a billion dollars a year from the federal government under the ACA to provide Medicaid health coverage to families earning under \$29,000 a year was a real mistake. There are many employees who would gain coverage under this provision and it is not right that they will be left out. Business benefits when workers come to work healthy and having health coverage—no matter how low income you are—is a part of that. Medicaid coverage also can help some businesses who have more than 50 full time low income employees avoid paying penalties since their workers can be covered by Medicaid.

3. Finally—we are doing some really innovative things aimed at small businesses in NC with our Medicaid Community Care program and NC Blue Cross—we are starting to test letting Blue Cross- insured businesses use our excellent health care networks under Community Care. This can save money, lower premiums and improve health care at the same time by coordinating our health care better, while using evidence to drive the kind of health care we deliver. This is the kind of innovation we need to see more of.

Thank you.

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Chairman ROE. Thank you, Mr. Searing.  
Mr. Conrad?

**STATEMENT OF KEN CONRAD, CHAIRMAN, LIBBY HILL  
SEAFOOD RESTAURANTS, GREENSBORO, NC**

Mr. CONRAD. Thank you, gentlemen, for the opportunity to testify before you today on behalf of the National Restaurant Association. My name is Ken Conrad, and I am Chairman of the Board of Libby Hill Seafood Restaurants. I currently serve as the Vice Chair of the National Restaurant Association. On any given day, 13 million Americans go to work in 980,000 restaurants in the United States. Our industry faces a number of challenges in implementing the law due to the unique characteristics of our workforce. I wish to highlight three of those for you today: one, the definition of a full-time employee; the complexity of a large employer determination; and potential harm that automatic enrollment provision could cause for some employees.

Libby Hill is a seafood distribution and restaurant company begun in 1953 when my father, Luke Conrad, first opened our doors. I am proud to say that my son, Justin, is the third generation of Conrads in this business. Our first restaurant is still located within the city limits of Greensboro, North Carolina. We have eight additional units in the state and Southern Virginia. We operate our

sales for those units, and we lease the remaining to the management team on location.

Libby Hill Restaurants employs 141 team members, of which 32, by the full-time definition as defined in the healthcare law, 32 are considered full-time. We have always used a 40-hour work week to determine who is full-time and part-time. So we will have to make changes on the new definition.

Today we offer a full medical plan and pay 80 percent of the premium for our corporate employees. That includes office staff, warehouse employees, truck drivers, et cetera. We try to drill down deeper in this carve-out program, but we could not get enough of the restaurant employees to come forward to have 75 percent covered under the plan. So we continue to pay all but one of our corporate employees to take this plan.

What employees will choose to do in 2014 when they are required to obtain coverage or pay a tax penalty remains an unanswered question that will impact our cost of offering coverage. The statute lays out a very specific and complicated calculation that must be used by employers to determine if they are applicable to be a large employer. As you might imagine, operators on the bubble of 50 full-time equivalent employees, which we are, are especially concerned in trying to understand what we must do to complete this complicated calculation. It is creating a lot of concern as these businesses, who have always considered themselves to be small, are now considered to be large.

At first brush, our company, we are on the verge of becoming a large employer. We must offer healthcare or face a substantial penalty, knowing from past experience that we are unlikely to get to the 75 percent participation level. We must do this calculation every year, and if we remain on the threshold of becoming a large employer, then we will not open any additional units because this insurance provision would be a game changer for our company.

The automatic enrollment requirement is a concern to many in the industry or that 200 full-time employees are automatically enrolled in healthcare. We think it is redundant and we think it is already covered. I want to thank Congressman Hudson and Congressman Robert Pittenger for proposing H.R. 1254 to repeal this part of it, and we appreciate your work on that.

In conclusion, since the enactment of the law, the National Restaurant Association has worked to constructively shape implementing the regulations of the healthcare law. Nevertheless, there are limits to what can be achieved through the regulatory process alone. At the end of the day, if this law remains in effect as it is currently written, restaurants and food service operators will face serious challenges.

Thank you again for this opportunity.

[The statement of Mr. Conrad follows:]

**Prepared Statement of Marshall "Ken" Conrad, Libby Hill Seafood Restaurants, Inc., on Behalf of the National Restaurant Association**

Chairman Roe, Ranking Member Andrews, and members of the Subcommittee on Health, Employment, Labor and Pensions, of the House Committee on Education and the Workforce, thank you for this opportunity to testify before you today on behalf of the National Restaurant Association. It is an honor to be able to share with

you the impact the 2010 health care law is having on businesses like mine, and the restaurant industry as a whole, particularly on our ability to create and grow jobs.

My name is Ken Conrad, and I am Chairman of the Board of Libby Hill Seafood Restaurants, Inc., a seafood restaurant first opened by my father Luke Conrad back in 1953. I am very involved in the seafood and restaurant industry here in the state and am the former Chairman of the North Carolina Restaurant Association. I currently serve as Vice Chairman of the National Restaurant Association.

The National Restaurant Association is the leading trade association for the restaurant and foodservice industry. Its mission is to help its members, such as myself, establish customer loyalty, build rewarding careers, and achieve financial success. The industry is comprised of 980,000 restaurant and foodservice outlets employing 13.1 million people who serve 130 million guests daily. Restaurants are job creators. Despite being an industry of predominately small businesses, the restaurant industry is the nation's second-largest private-sector employer, employing about ten percent of the U.S. workforce.<sup>1</sup>

*The Libby Hill Seafood Restaurants story*

My family continues to own and operate Libby Hill Restaurants and I'm proud to say that my son Justin is the third generation of Conrad's in the business. Our first restaurant is still located within the city limits of Greensboro, North Carolina with locations scattered across North Carolina and Virginia. Four of the restaurants are part of Libby Hill Restaurants, Inc., with the remaining 5 separately owned and operated by others. My company also includes a seafood distribution company. We cook some of the best seafood in the area, and you know that every Libby Hill Restaurant is a family-friendly kind of place.

Libby Hill Restaurants, Inc. employs 32 full time employees and 109 part-time employees based on the new definition of full-time employment within the health care law. We have always used a 40 hour work week to define who is full-time and part-time within our company, and so we will have to make changes based on this law's new definition of full-time at 30 hours a week on average in any given month.

Today, we offer a full medical benefits plan and pay 80 percent of the premium, but only 10 employees take the plan. As a result we have a carve-out plan for our corporate office staff, our warehouse employees and our truck drivers. We have tried to offer coverage to our restaurant employees in the past, but not enough employees opted in for the company to even be able to purchase a plan. To offer coverage, we needed a minimum participation of 75 percent of the eligible employees to take our offer of coverage, but that was not the case when all of our staff was included. As a result, we had to limit the eligibility pool to a smaller group of employees to be able to offer coverage to anyone. Level of participation in restaurateurs' plans has been a long-standing challenge in our industry. I am concerned that even with the new law's requirements for individuals, employees who are eligible for our offer of coverage will not accept it and choose to pay individual mandate tax penalty instead.

Business owners crave certainty and one of the most difficult things to predict about the impact of this law is the choice employees will make. Will they accept our offer of minimum essential coverage? Will exchange coverage be less expensive than what we can afford to offer under the law? Will our young workforce choose to pay the individual mandate tax penalty instead of accepting our offer of coverage in 2014, 2015 and beyond? Future take-up rate of coverage is very hard to predict given many new factors, but could mean increased costs for employers when offering coverage.

*Complying with the health care law is challenging for restaurant and foodservice operators given the unique characteristics of the industry*

Since the law was enacted in 2010, me and my staff have educated ourselves about the requirements of the law, the details of the Federal agencies' guidance and regulations, and to understand how to implement the necessary changes within our organization. Understanding our compliance requirements has been time consuming and burdensome. Currently we do not have human resources personnel on staff responsible for administering the health benefits program as part of their duties. Instead, we are relying on our lawyers and outside vendors to help us determine our options and implement the law within our business. This is typical of restaurants of similar size to our operations. Our Chief Financial Officer has primary responsibility for developing our strategy and plan to comply with the law. Both he and I have spent a significant amount of time trying to understand the impact so that educated business decisions can be made.

<sup>1</sup>2013 Restaurant Industry Forecast.

Until the January 2, 2013 Federal Register publication of the Treasury Department's Proposed Rule regarding the Shared Responsibility for Employers provision, employers did not have any firm rules on which they could plan and make business decisions. Up until this time, proposals and guidance had been issued with numerous opportunities for public comment, but nothing had the weight of regulation. This proposed rule, while not finalized, does provide employers assurances that the rules proposed can be relied upon until further rules are issued.

Our Association has been educating the industry since enactment and doing everything we can so that operators know that now is the time to take action to comply. While many rules and guidance have been proposed, questions still remain regarding exact implementation of many of the employer requirements.

The unique characteristic of our workforce creates compliance challenges for restaurant and foodservice operators. As a result, many of the determinations employers must make to figure out how the law impacts them—for example the applicable large employer calculation—are much more complicated for restaurants than for other businesses who have more stable workforces with less turnover.

Restaurants are employers of choice for many looking for flexible work hours and so we employ a high proportion of part-time and seasonal employees. We are also an industry of small businesses with more than seven out of ten eating and drinking establishments being single-unit operators. Much of our workforce could be considered “young invincibles,” as 43 percent of employees are under age 26 in the industry.<sup>2</sup> In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.<sup>3</sup>

All of these factors combine to complicate what a restaurant and foodservice operator must consider when implementing the necessary changes in their business to comply with the law. My company is a great example as we have spent a large amount of time trying to understand the law and what we must do to comply, but still do not know the answers to many questions.

#### *Applicable large employer determination*

The statute lays out a very specific calculation that must be used by employers to determine if they are an applicable large employer and hence subject to the Shared Responsibility for Employers and Employer Reporting provisions. Because of the structure of many restaurant companies, determining who the employer is may not be as easy as it would seem.

Aggregation rules in the law require employers to apply the long standing Common Control Clause<sup>4</sup> in the Tax Code to determine if they are considered one or multiple employers for the purposes of the health care law. While these rules have been part of the Code for many years, this is the first time many restaurateurs, especially smaller operators, have had to understand how these complicated regulations apply to their businesses. The Treasury Department has not issued, nor to our knowledge, plans to issue, guidance to help smaller operators understand how these rules apply to them. Restaurant and food service operators must hire a tax advisor to determine how the complicated rules and regulations associated with this section of the Code apply to their particular situation. It is common that business partners of one restaurant company own multiple restaurant companies with other partners. These restaurateurs consider themselves to be separate businesses, but because there is common ownership, under the rules many are discovering that all the businesses can be considered as one employer for purposes of the health care law.

Once a restaurant or foodservice operator determines what entities are considered one employer, they must determine their applicable large employer status annually. This is not an easy calculation. My business is on the bubble of being an applicable large employer defined as employing 50 full-time equivalent employees on business days in a calendar year. We must consider the number of full-time employees now based on 30 hours a week, as well as the hours worked by all our other employees. Given we are an industry of small businesses and that restaurants are labor intensive and require many employees to operate successfully, many small businesses will have to complete this calculation annually to determine their responsibilities under the law. I may be one of them.

As you might imagine, operators like myself who are on the bubble of 50 full-time equivalent employees are trying to understand what they must do to complete this complicated calculation each year. Generally, an employer must consider the hours of service of each of their employees in all 12 calendar months each year. However,

<sup>2</sup> Bureau of Labor Statistics, U.S. Department of Labor.

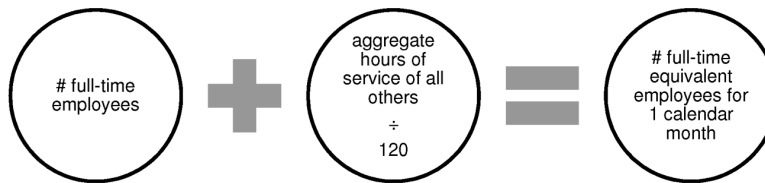
<sup>3</sup> 2013 Restaurant Industry Forecast.

<sup>4</sup> Internal Revenue Code, §414 (b),(c),(m),(o).

the Treasury Department has allowed for transition relief in 2013 for businesses to use as short as 6 months to do this calculation. The Treasury Department recognized the fact that small businesses, who may not currently offer health coverage, will need time to determine their status and then negotiate a plan with an insurance carrier. However, there remain questions about the process in later years when January through December must be considered for status beginning the following January 1st. Will small employers just reaching the applicable large employer threshold find that they determine they are large on December 31, 2014, for example, and must offer coverage a day later on January 1, 2015? Rules are needed to clarify when such employers must offer coverage in future years.

The applicable large employer determination is complicated. For compliance beginning in 2014, employers must determine all employees' hours of service each calendar month, calculate the number of FTEs per month, and finally average each month over a full calendar year to determine the employer's status for the following year. The calculation is as follows:

1. An employer must first look at the number of full-time employees employed each calendar month, defined as 30 hours a week on average or 130 hours of service per calendar month.
2. The employer must then consider the hours of service for all other employees, including part-time and seasonal, counting no more than 120 hours of service per person. The hours of service for all others are aggregated for that calendar month and divided by 120.
3. This second step is added to the number of full-time employees for a total full-time equivalent employee calculation for one calendar month.



4. An employer must complete the same calculation for the remaining 11 calendar months and average the number over 12 calendar months to determine their status for the following calendar year.

This annual determination is administratively burdensome and costly, especially for those just above or below the 50 FTE threshold who must most closely monitor their status—most likely small businesses. Many restaurant operators rely on third-party vendors to develop technology or solutions to help them comply with these types of requirements but vendors are backlogged and solutions are not widely available today.

#### *Offering coverage to full-time employees*

The 2010 health care law requires employers subject to the Shared Responsibility for Employers provision to offer a certain level of coverage to their full-time employees and their dependents, or face potential penalties. The statute arbitrarily defines full-time as an average of 30 hours a week in any given month. This 30-hour threshold is not based on existing laws or traditional business practices. In fact, the Fair Labor Standards Act does not even define full-time employment. It simply requires employers to pay overtime when nonexempt employees work more than a 40-hour workweek. As a result, 40 hours a week is generally considered full-time in many U.S. industries. Certainly in the restaurant and foodservice industry, operators have traditionally used a 40-hour definition of full-time. Adopting such a definition in this law would also provide employers the flexibility to comply with the law in a way that best fits their workforce and business models.

This is complicated by the fact that sometimes it is difficult to know who the full-time employees will be in a restaurant. For restaurant and foodservice operators who are applicable large employers, it is not easy to predict which hourly staff might work 30 hours a week on average and which will not. Many employees' hours can be unpredictable week to week.

During periods of high customer traffic during the year, employees are scheduled to work more hours to maintain the customer's expected level of service, but then hours are reduced as business slows. Some weeks an employee might pick up extra shifts to earn a little extra in their paycheck that month, and others they prefer a few less hours because of commitments outside the restaurant. This is one of the attractive benefits of our industry—the flexibility to change your hours to suit your

own personal needs. However, for the first time under this law, the federal government has drawn a bright line as to who is full-time and who is part-time. As a result, employers with variable workforces and flexible scheduling must be deliberate about scheduling hours because there is now potential liability for employer penalties if employees who work full-time hours are not offered coverage.

The industry appreciates that the Treasury Department has recognized that it may be difficult for applicable large employers to determine employee's status as full-time or part-time on a monthly basis, causing churn between employer coverage and the exchange or other programs. Such coverage instability is not in the employee's best interest and so the restaurant and foodservice industry is pleased that the Lookback Measurement Method is an option that applicable large employers may use.

The Lookback Measurement Method's implementing rules are complex but it could be helpful for both employers and employees. Employers will be better able to predict costs and offer coverage to employees they are required to offer to, and employees whose hours fluctuate have the peace of mind of knowing that if their hours do drop, coverage will not be cut short before the end of their stability period. The Lookback Measurement Method can only be applied to variable hour or seasonal employees. Employers cannot consider the length of time of service of these employees, only that their hours are unpredictable and that they fluctuate.

#### *Automatic enrollment requirement*

Applicable large employers who employ 200 or more full-time employees are also subject to the Automatic Enrollment provision of the law. This duplicative mandate requires the employer to enroll our new and current full-time employees in our lowest cost plan if they have not opted-out of the coverage. This provision also interacts with the prohibition on waiting periods longer than 90 days and effectively means that on 91 day, we must enroll a new full-time hire in our lowest cost plan if they do not tell us that they do not want to be enrolled. Employee premium contributions will begin to be collected and the industry is concerned that it could cause financial hardship and greater confusion about the law, especially amongst our young employees. Since 43 percent of restaurant employees are under age 26 and more likely to be moving from job to job or eligible for enrollment in parents' plans, many are likely to inadvertently miss opt-out deadlines and will be automatically enrolled in their employer's health plan causing significant, unexpected financial hardship.

Automatically enrolling an employee and then shortly thereafter removing them from the plan when the employee opts-out only increases costs unnecessarily without increasing our employee's access to coverage as the law intended. Since the health care law's employer mandate already subjects large employers to potential penalties if they fail to offer affordable health care coverage to full-time employees and their dependents, the auto-enrollment mandate is redundant. It adds a layer of bureaucracy and burdens businesses without increasing employees' access to coverage.

Some compare automatically enrolling employees in health benefit plans to automatically enrolling them in a 401(k) plan, but this isn't a good parallel. The financial contribution associated with health benefits can be much larger, for example: 9.5 percent of household income toward the cost of the premium for employees of large employers versus an average 3 percent automatic 401(k) contribution. The financial burden on employees of automatic enrollment in health benefit plans would be much greater than that of 401(k) plans. Additionally, 401(k) rules allow employees to access their contributions when they opt-out of automatic enrollment; however health benefit premium contributions cannot be retrieved.

Restaurateurs will educate their employees about how this provision impacts them, but if an employee misses the 90-day opt-out deadline, a premium contribution is a significant amount of money, which can be a financial burden. Since the same full-time employees must be offered coverage by the same employers subject to the Automatic Enrollment provision and the Shared Responsibility for Employer provisions, we believe the automatic provision is unnecessary and should be eliminated.

I want to acknowledge and thank Congressman Richard Hudson for his leadership in introducing H.R. 1254, the Auto Enroll Repeal Act recently, together with Congressman Robert Pittenger. Enactment of this measure would eliminate this requirement that could hurt both employees and employers. The National Restaurant Association supports passage of H.R. 1254 and looks forward to working with Congressmen Hudson and Pittenger and this Subcommittee to move the bill forward in Congress.



*Challenges for applicable large employers offering coverage to their full-time employees and their dependents*

Once an applicable large employer has determined to whom coverage must be offered, he must make sure that the coverage is of 60 percent minimum value and considered affordable to the employee, or he may face potential employer penalties.

Minimum value is generally understood to be a 60 percent actuarial test; a measure of the richness of the plan's offered benefits. This is a critical test for employers especially as it relates to what an employer's group health plan covers and hence what the premium cost will be in 2014. Business owners like certainty and that means the ability to plan for their future costs.

Employers are eager to know what their premium costs will be under the new law. Minimum value is key to determining that information.

On February 25, 2013 the Health and Human Services Department did include the Minimum Value Calculator, one of the acceptable methods to determine a plan's value, in its Final Rule, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Minimum value can now be determined using this calculator but still it is difficult to know premium costs so far in advance. For our January 1st plan year start date, we do not anticipate being able to obtain premium pricing for several more months. With a potential increase in cost, this gives us a short timeframe within which to make business decisions in advance of the new plan year. Any plan design or other changes to help control our costs will be part of our budgeting process going forward.

Employers must also ensure at least one of their plans is affordable to their full-time employees or face potential penalties. A full-time employee's contribution toward the cost of the premium for single-only coverage cannot be more than 9.5 percent of their household income, or else the coverage is considered unaffordable. Employers do not know household income, nor do they want to know this information for privacy reasons. However, employers needed a way to be able to estimate before a plan is offered if it will be affordable to employees. What employers do know are the wages they pay their employees. Almost always, employees' wages will be a stricter test than household income. Employers are willing to accept a stricter test in the form of wages so that they know they are complying with the law and are provided protection from penalty under a safe harbor. The Treasury Department will allow employers to use one of three Affordability Safe Harbors based on Form W-2 wages, Rate of Pay or Federal Poverty Line. We believe that the option of utilizing these methods will be helpful to employers as they determine at what level to set contribution rates and their ability to continue to offer coverage to their employees.

Our company has looked at this particular issue within the law, but we do not believe we will have to worry about the affordability of our plan for our employees, at least in the first year. As I previously mentioned, our company pays 80 percent of the total premium cost for the plan we offer. The remaining 20 percent of the premium, that we currently ask our employees to contribute, is less than 9.5 percent of our employees' wages. Hence, if premiums do not increase we believe that our current practice will satisfy the affordability test and changes to employee contributions are not necessary for our next plan year.

The law speaks to affordability for employees but is silent regarding whether the coverage required to comply with the Shared Responsibility for Employers section of the law is affordable to employers. We anticipate added costs as a result of this law, either through required changes impacting plan design or additional fees—such as the PCORI Funding Fee, the Exchange Reinsurance Program Fee, the Health Insurance Provider Fee—that will continue to drive up premiums for employers and employees as others pass along these increased costs. In addition, new taxes such as the "Cadillac" tax on certain employer-sponsored coverage, will also squeeze restaurants when it begins in 2018.

As restaurant and foodservice operators implement this law, considering all of the interlocking provisions that impact employers, some will be faced with difficult business decisions between offering coverage which they cannot afford and paying a penalty for not offering coverage that they equally cannot afford nor want to do. We encourage all policymakers to address the cost of coverage so that the employer-sponsored system of health care coverage will be maintained.

*New nondiscrimination rules applied to fully-insured plans*

The health care law applies the nondiscrimination rule, that self-funded plans cannot offer benefits in favor of their highly-compensated individuals, now to fully-insured plans. This rule is not in effect as the Treasury Department has put implementation on hold until further guidance has been issued in this complex area. Under the new law, these rules apply to all insured plans, regardless of where they

are offered by an applicable large employer or a small business. The restaurant and foodservice industry is watching this rule closely as it may impact what plans may continue to be offered to employees.

Current group health plan participation often forces operators to carve out the group of employees who will participate in the plan. In our members' experience, these are almost always a group that would be considered in the top 25 percent based on compensation.

However, management carve-outs are not just for upper level executives who may receive richer benefit plans than the rest of the employees. In the restaurant and foodservice industry, management-only plans are sometimes the only option that operators have to provide health care coverage to those employees who want to buy it and pass participation requirements at the same time. As a result, these plans are quite common in the industry. This was the situation I encountered when we tried to offer coverage to more employees several years ago.

The rules the Treasury Department writes to apply non-discrimination testing to fully-insured plans will have an impact on our industry. Regardless of how they are written, restaurant and foodservice operators will need sufficient transition time to apply these rules as it could create upheaval for plans and employers alike.

#### *Applicable large employer reporting requirements*

A key area of implementation that employers have not received guidance on are the employer notice and reporting requirements: the Fair Labor Standards Act Notice to Employees from the Department of Labor, the notices and appeals processes with Exchanges from the Department of Health and Human Services, and the required information reporting under Tax Code §6055 and §6056 from the Treasury Department. These employer notice and reporting requirements are a key link in the chain of the law's implementation. They represent a significant employer administrative burden as well as rules that will help employers ensure that their employees are well informed about their options under the law. Operators are aware of this requirement and ask often when guidance and a template for this notice will be available from the Labor Department.

Of particular concern to the industry, is the flow of information and the timing of reporting employers must make to multiple levels and layers of government. Streamlining employer reporting will help ease employer administrative burden and simplify the process. The information provided by employers under Tax Code §6055 and §6056 is critical in this process and can be used by the Treasury Department to verify if an individual had an offer of affordable minimum essential coverage of minimum value from an applicable large employer. The information provided by employers must be compared by the Internal Revenue Service to verify eligibility determinations made by the Exchanges for premium tax credits or cost-sharing reductions. The information can also be used to determine employer penalty liability. The restaurant and foodservice industry, along with other employer groups, have advocated for a single, annual reporting process by employers to the Treasury Department each January 31st that would provide prospective general plan information and wage information for the affordability safe harbors, as well as retrospective reporting as required by §6056 on individual full-time employees and their dependents.

We are anxious for guidance to be issued on all of these interrelated issues, as employers cannot just flip a switch and produce the detailed information reports required by the law. It will take time for employers to set up systems, or contract with vendors, to track and maintain the data needed to comply with the law. When I think of our own company and the detailed information we will have to track and report on all full-time employees and dependents, it is a large amount of data. The reporting will include not only the employees who remain with the restaurant for the entire year, but even our seasonal staff and others who may only stay for a couple of months. Health plan benefit information as well as individualized payroll-sourced information must be merged to produce the report needed under the law.

#### *Transition relief*

Within the Proposed Rule for Shared Responsibility for Employers, the Treasury Department provided targeted transition relief. While appreciated, we believe that further transition relief is critical. The timeframe for compliance is short and getting shorter and safe harbor protections for good-faith compliance by employers in the law's early phases is necessary. Employers are still missing essential pieces of guidance and regulation necessary to construct their systems, make plan design changes and communicate with their employees with 8 months until the first of the year. Under the threat of heavy penalties for not getting this exactly right the first time, some employers may opt-out of offering coverage to their employees and

choose to pay the penalties instead. This is not what the restaurant and foodservice industry wants, but it may be a likely result of employers having to make difficult decisions under extremely uncertain conditions. The process should not discourage employers and employees from participating in the new system and the application of a good-faith compliance standard is appropriate. As with implementation of any law this size, it will take some time for the hiccups in the processes to be worked out and employers should be allowed adequate time to come into compliance.

#### *Conclusion*

Since enactment of the law, the National Restaurant Association has worked to constructively shape the implementing regulations of the health care law. Nevertheless, there are limits to what can be achieved through the regulatory process alone. Ultimately, the law cannot stand as it is today given the challenges employers such as restaurant and foodservice operators face in implementing it.

Broader transition relief is needed for employers attempting to comply with the law in good-faith as time is short to make the significant changes required by the law. The duplicative automatic enrollment provision should be eliminated as it could unnecessarily confuse and financially harm employees. Key definitions in the law must be changed: The law should more accurately reflect the general business practice of 40 hours a week as full-time employment. The applicable large employer determination is too complicated, and over-reaches to include more small businesses than it should.

The National Restaurant Association looks forward to working with this Committee and all of Congress on these and other important issues to improve health care for our employees without sacrificing their jobs in the process. We also continue to actively participate in the regulatory process to ensure the implementing rules consider our industry's perspective.

Thank you again for this opportunity to testify today regarding the impact of the health care on the restaurant and foodservice industry, and the challenging environment it will cause for job creation and growth.

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Chairman ROE. Mr. Conrad, thank you, and thank you to the panel for your very, very good testimony. I read every bit of it last night.

I would like to start by just saying a few things about how I share the vision and goal of providing health insurance coverage for everybody in this country. I live in rural East Tennessee, in Appalachia, and I have seen many, many people who don't have health insurance, and as an OB/GYN doctor, I have delivered almost 5,000 babies, and I did find out that when you run for Congress, delivering your own voters worked out pretty well for me. [Laughter.]

So I would recommend, if you are a doctor, deliver a lot of babies. They grow up and vote, and I saw some yesterday.

Obviously, we have made this incredibly complicated. As I stated, I am on the Veterans Affairs Committee, and I spent two hours and 15 minutes this week just looking at the effect of the Affordable Care Act on veterans. After two hours of testimony, we couldn't figure it out. Nobody walked out of the room—and these were smart people, IRS, Treasury, the chief medical officer of the VA.

Mr. Searing, to your comment, there are many parts or parts of this bill that I agree with, the under 26. I had three kids of my own. The problem with it is that we took something that was very affordable, and what we did for young people was, actuarially, someone my age would pay six times—that is the risk I have—six times more than a young person. What we did was, by this law, you can now only charge at 3-to-1. So a young person who had very inexpensive, affordable coverage, we just doubled or tripled the cost of their coverage. I have had insurance agents already tell me in

the small group market, the individual market, those rates are up 25 percent, 35 percent. Bill Gates is not going to be able to afford healthcare if we don't do something.

The OMB, the Office of Management and Budget, estimated that in 2016 the average family of four's health insurance coverage will be \$20,000 a year. I mean, that is not sustainable.

We took a bill, this bill, which I read every word of it, which doesn't say much about my intelligence but I read all 2,700 pages of it, there are now over 13,000 pages of rules and regulations that these business people right here have got to go over. Let me give you an example.

Mr. Horne—and I am going to let him answer this—we had the self-insured market. When I was the mayor of Johnson City, I practiced full-time and I was mayor of Johnson City. It is not a big town, about 60,000 people, so I did both. We were self-insured. Well, now we find out that when you are self-insured—and one company that came to me, I won't mention it but it is a national company, is totally insured. They don't have any reinsurance or anything. They pay every nickel that they pay. They derive no benefit from the Affordable Care Act whatsoever. But guess what they get? They get \$63, not per family, per person covered. It is a \$25 million hit for them this year.

And you know what that money does? It indemnifies the private health insurance companies so that they won't have a risk in the exchange of more than a \$60,000 loss. So here is a company doing exactly the right thing. I couldn't think of anybody, Mr. Horne, doing more right for your employees than you are, providing preventive services, totally free for them, a nurse on site to take care of problems, and what do you do? You get penalized for that.

So how much—would you go through what the cost is for your business again in your small business of 350 employees?

Mr. HORNE. We have 350 employees, and there are 515 covered individuals. So that \$63 will be times 515 people in our case, a little over \$32,000.

One of the issues also is that we keep learning things. Just yesterday, I learned that we will now pay \$2 per covered individual to pay for the Patient Centered Outcome Research Institute, whatever that is. We just keep learning these things as time goes by.

Chairman ROE. Well, another point on the thing that we use and would recommend is our high-risk pools for people with pre-existing conditions. We explained to the administration you did not put in—we have a high-risk pool in Tennessee. You did not put enough money into the high-risk pools. So they didn't. They ran out of money, and right now they are not enrolling anybody else in high-risk pools. So if I had patients that came to me that developed breast cancer, that is the most common cancer that I saw, and the cure rates now for early breast cancer is 95 percent. It is phenomenal. And yet, these patients now have a pre-existing condition. So they go back into the workforce after their treatment and they couldn't find coverage. So we have a high-risk pool to help cover that.

The Obama Administration is now taking money out of preventive services, which we tried to prevent, to pay for advertising for the Affordable Care Act. So money is being taken out of a service

that you, Mr. Searing, mentioned, to help people, and we knew that the high-risk pools were underfunded, greatly underfunded. They need to be funded where someone who has that can go to that pool and buy insurance at the same rate that I can or someone else who is healthy can.

Ms. Haynes, I thought your testimony was really very, very good. We have two community colleges in my district, and I say this tongue-in-cheek. I sort of overdosed on education. I went for 23 years, and my dad kept saying when is that boy ever going to get out of school. I was raised on a farm, and my dad was a factory worker. So I used education, public education, not private. I never went to a private school in my life, all to public schools, how important that is to be able to make sure that these young people, with the cost of education being what it is today—would you elaborate on that a little bit for me?

Ms. HAYNES. Certainly. I think the important point here is that it costs us about \$450 a month per employee to provide health care coverage. Any coverage that we provide, obviously, at some point in time the student is going to incur the cost because we are funded through taxpayer dollars, obviously, and anything that costs the college ultimately costs the students. So in order to provide that coverage, it is a path through to the students.

The difficulty I think becomes, with this too, is that the adjunct faculty have an impact that was unintended. We have no way to fund insurance. We believed that the healthcare exchanges would be the appropriate way for them to be able to purchase that coverage that they need. And yet, now they will have less income because we cannot provide them the number of courses that they would have had to have taught before in order to be able to purchase that as well.

So it is an impact across the board. You have students now who won't get classes that they potentially would have had in the sequence that they would have been able to do, so it slows their progress. They don't become taxpayers and contributors as quickly. So there is a tremendous impact there.

Chairman ROE. I thank you, and I now yield to Mr. Hudson.

Mr. HUDSON. Thank you, Mr. Chairman.

I thank the witnesses for your excellent testimony.

Mr. Conrad, I was listening to your testimony, and you said that you do not employ any outside HR folks to help you deal with those issues. Now with the new law, are you going to need to probably bring in some HR folks? What kind of cost are you looking at for trying to comply with this law?

Mr. CONRAD. To begin with, we have been scratching the surface. I have gone to accountants, I have gone to lawyers. I haven't brought the certified HR people in. But on first brush, the low number was \$160,000 a year to over \$200,000 a year, just to expand on what we are presently doing, the 80 percent for corporate people. So we know it is going to be quite expensive, but we just don't know how expensive.

I don't think all those numbers, Congressman, are going to come out until November. I think we are all, the experts, just sort of playing a guessing game until then, because until they get into the

fourth quarter, they are not going to give us any rates for 1 January 2014.

Mr. HUDSON. So what is the impact of this uncertainty on you? What are you doing to prepare for whatever the eventuality might be?

Mr. CONRAD. Well, let me back up and say that the restaurant business in itself is one of the very lowest profit-per-employee industries in the United States. With 10 percent of the workforce employed in a restaurant or a food service operation today, and that is directly, not all the indirect people that depend on that, we are in dangerous territory. The mortality rate for a restaurant today on the average is they are not going to last 36 months. So if you stop and look, it is a changing industry. It is one, when you look at the profit per employee, why did we ever go into the business to begin with? But we were just born into it and we love it.

Mr. HUDSON. I appreciate that, and I love eating the fried fish that you serve up. [Laughter.]

So you talk very specifically about a couple of different items in the law that are having an impact on you, and we are working on one of those together, on the auto enrollment. But which of these do you think is the most critical, or could you talk a little more about it?

Mr. CONRAD. I think right now the defining deal with 30 hours a week, a lot of employers right now are trimming their workforce back to 29, 29 hours, and people are having to find multiple jobs. I think if you were to go to a more realistic number of 35 to 40, that may give an umbrella to some of those people that are going to be impacted.

I think the definition of large employer/small employer is very critical because the equivalency of—somebody mentioned talking about the three people working in—I think it was you, Chairman—that were working in the summer to relieve their college deals, and then you add their hours up, and that equates to one full-time employee. And so I think that could be relaxed somewhat, the equivalency part of it.

Mr. HUDSON. Thank you for that.

I have a little bit of time left. Mr. Horne, I would like to go back to you. I introduced you to the Chairman earlier as an endangered species because you are a textile person who has been very successful, and you have a reputation in your community of being an outstanding corporate citizen, and I hope folks noted that you didn't call your employees "employees." You call them partners, and I was very impressed the more I learned about the things you do preventive care-wise and others to provide benefits to your employees.

But with the costs coming down the pike, \$63 per individual and so forth, what kind of impact is that going to have on your ability to continue to provide these benefits to your workers, your partners?

Mr. HORNE. Well, I am sure we will continue to provide the benefits. There is no question about that. The conversations that we are having right now are what are we going to do to help control our costs, and oftentimes that comes down to not replacing people, using attrition to reduce the numbers. So I think that is going to

be the likely outcome of all this. Certainly, we are going to pay quite a bit more.

There is another issue, too, and that is that we think there is going to be a morale issue here. We have some young employees who choose not to take our health insurance. It may not be the best decision, but we have that, and, of course, we are going to have to automatically enroll them. They have no choice in that. And I feel like the response is going to be to be angry at us about that as opposed to the law, and it is going to be difficult to explain that.

Of course, our premiums for single individuals is \$23 a week. So it is going to cost them a little over \$1,000 when we enroll them. They can easily withdraw and pay the penalty, and they would be much better off.

Mr. HUDSON. Thank you.

My time has expired. Mr. Chairman, I will yield back to you.

Chairman ROE. I thank the gentleman for yielding.

We will have a second round of questions. Let me start off by saying there is a large fast food chain in Tennessee that has 70 percent full-time employees and 30 percent part-time. Instead of growing their business this year, their model is going to be to flip that number to 70 percent part-time and 30 percent full-time.

Let me give you an example in my own—I asked Secretary Sibelius, and she will be in front of our committee on the 15th of May. But I asked Secretary Sibelius last year, I said, look, I am in a medical practice, and we pay about \$6,000 per employee for health insurance coverage. We have covered our employees and have been proud to do it since 1967 when we opened our practice. So I said we have 400 employees. We are paying \$6,000 each. If I pay a penalty of \$2,000 each, that costs me \$800,000, and I can save myself \$1.6 million. Why won't I do that? And she had no answer.

Mr. Horne had the answer, is because we want to do the right thing by our employees. We think we get better employees. So, therefore, you want to do that.

We had testimony from a guy, an HR firm last year, who came in and said one of his clients said I am not going to be the first one to drop my health insurance coverage, but I am not going to be third either. And what he meant was that he will be at a competitive disadvantage if some of his competitors drop that and they can put that money to their bottom line. I can tell you, I know of one large company, a Fortune 500 company that is in Tennessee that can put \$40 million to their bottom line by simply putting their employees into the exchange, and let me tell you why that is a bad idea for the employees, because the subsidy that they get through the exchange is not as much as their employer is currently paying, and the difference between those numbers that the employee will have to pay is not tax-deductible.

So once again, I will go back to the first premise I made. The biggest problem with healthcare in this country is the cost of it, how much it costs people. If it were all cheap, we would all have it. I absolutely believe that there is enough money in our system to cover all of our citizens.

Let me just give you a brief example of Tennessee when we reformed our Medicaid program. We are going to get to that in our

second panel. The problem in Tennessee in the early 1990s, we had a lot of people—we are not a wealthy state. Our per capita income is less than the national average. We wanted to provide health insurance coverage for as many people in Tennessee as we could. So we reformed in a managed care plan called TennCare.

We found out we were spending \$2.5 billion in 1993. In 2003, we were spending \$8.5 billion. Our costs had over tripled in 10 years, and half the people who had health insurance coverage, half the people who got on TennCare dropped their private health insurance and got on the public, and the reason they got on that was it was a better plan than I could afford in my office.

So the state, what it did was, our Democratic governor, to his credit, in 2005, basically how he rationed care was he just cut the rolls. That is what he did.

So I have seen this health care reform done before. I had written an article about it three years ago about how I see it going down. Look, healthcare decisions ought to be made between a patient and the doctor and that patient's family. It shouldn't be made between an insurance company telling you what you can have done or the Federal Government telling you what you can have done. That is the most personal decision you can possibly make, and that is who should be making it.

I admire all of you. Every bit of testimony here has been spot-on correct.

Mr. Conrad, I want to go back to the auto enrollment. My kids are all above 26 now, but when they were less than 26, I think they would have made a decision, instead of paying \$300 a month, to pay \$95 a year, opt out, and the whole premise of this Affordable Care Act is that you are basically going to extract healthy people. Look, the healthiest people in the world are people under 26 years of age. The only thing you are insuring a less than 26-year-old boy for is just stupidity. They are going to do dumb stuff. [Laughter.]

I have two boys. I understand what they do. You are insuring stupid. You are not insuring disease.

So what you are doing at that point is you are taking people who don't have much risk and forcing their costs up. When they figure that out, and they will in about 10 minutes, they are going to opt out of the auto enroll.

Mr. Conrad, what you mentioned about how you can dual enroll people, I don't think most people understand that a husband and wife can be working, both get auto-enrolled at different jobs and both be on an insurance plan when only one of them needs to be.

Mr. CONRAD. And then the children also are covered under mom and dad's plan, and they are not needing to be there. We just think the redundancy of the 200 employee limit, it is already in the large employer. It is already there. You have to offer that health insurance. Just like the gentleman said, he is offering it to all of his employees. Not all will take it.

The auto enrollment is going to create ill will for those people who really didn't want health insurance and all of a sudden they get that check on the 91st day and it has them enrolled in health insurance and they didn't sign up for. All of a sudden, you have another problem with the morale of your employees. We just feel like



H.R. 1250, whatever it is, is the right bill to come out of Congress to get rid of this.

Chairman ROE. Well, I thank you.

One last comment, and then I will yield to Mr. Hudson.

The only people I know of who define a 30-hour work week as a full work week would be the French. [Laughter.]

I yield to Mr. Hudson.

Mr. CONRAD. And see where it got them.

Mr. HUDSON. Mr. Chairman, I don't know how to follow that.

Ms. Haynes, I would like to talk some about the issue you raised with adjunct professors. You discussed calculating the hours worked both inside and outside the classroom for the purpose of the 30-hour part-time calculation and the healthcare law. By your math, an adjunct faculty member would not be able to teach more than three 3-hour credit courses at one time. How much of a departure is this from current practice, and what is going to be the real impact? Have you calculated how many courses we may lose at the college with this?

Ms. HAYNES. Well, it varies by college, and it varies by subject matter. So it would be difficult to say exactly what the impact is going to be. But I can tell you that it can be substantial. I mean, at a point in time we can use adjunct faculty to teach four, five, or even six classes. And it depends on the type of class. All classes and all courses are not created equal. You have those that are purely lecture. They require an intense amount of preparation ahead of time. And then there are classes, like welding or some cosmetology, for example, where the instruction and the lab take place simultaneously. So most of the preparation and the instruction, everything, happens within the content and the context of that classroom.

So there is not a lot of preparation that happens outside, nor supporting or needful activity outside of the classroom. It all happens within. So defining that and giving us a one-size-fits-all rule really just doesn't work for the type of instruction that we deliver.

Mr. HUDSON. Well, I appreciate that. You also mentioned the massive administrative burden on the college. Can you elaborate on that a little bit?

Ms. HAYNES. Well, let's see. I was thinking just before we came, there is the look-back period, the measurement period, the stability period, and then there is the initial measurement period for new employees, and administrative period, and all of that is followed by additional enrollment. So you just keep this going on and on and on.

We also have employees who work for us, and faculty, for example, adjunct faculty, they will teach for us for a year and then, for whatever reason, they drop out a year, either by our demand or because they are going back to school. Whatever the reason, they may be with us a year, they leave a year. So during that measurement period, they are entitled under the eligibility rules to participate in our health plan, but they are no longer with us. So you have payroll deduction that would have occurred had they still been employed, but they are not there.

So now we have to set up collections. You have to figure out how to get that money, and we believe that in most cases people are

honorable and they follow up on their debts. But sometimes, let's face it, it is just difficult to collect, and that is part of what we are going to have to look at.

In addition to that, you have to look at all of these different employee populations, and the penalties, I might mention, are tremendous. We couldn't afford the penalty if we hit that penalty bracket. So we have to be extra careful. It is a massive undertaking to set up the administration to do the eligibility, to look at eligibility, to make sure that always you are defining every population for every measurement period and every stability period and every enrollment correctly.

Mr. HUDSON. Wow. I heard you say in your testimony before what is going to happen to the added cost. Would you repeat that and highlight what you said?

Ms. HAYNES. Well, if you consider that we have \$5,400 roughly in employer costs when we cover someone, that cost has to go somewhere. Frankly, you and I both know as taxpayers, there is not a whole lot more in the taxpayer base, in our taxes, that we can apply towards that. And so ultimately, I think it will become a student expense. It has got to trickle through. That is really not where we want to put that cost. Students need to be able to kind of get that education, and frankly, that slows down our entire economy. We are looking to help that student along. We don't want to be the impediment. We want to help them get their education and get in that workforce.

Mr. HUDSON. Absolutely. And this college's ability to respond to the needs of employers and the needs of students that need certain skills is why this college is so critical, and other colleges like South Piedmont that, Mr. Horne, you deal with. They supply the type of skilled workers you need in your business, and the ability to adapt to that, to get students who need those skills matched up with those skills. It really concerns me to hear that we may see increased costs to try and comply with this law that could then limit the access students have to those skills. So I appreciate you raising that issue.

Mr. Chairman, I yield back.

Chairman ROE. I thank the gentleman for yielding, and I want to thank the panel.

Just to show you, Ms. Haynes, how I share in your confusion, I am supposed to be an expert in this healthcare law, and I can't even tell you, I can't even tell my employees in Washington and in my district office what their health insurance is going to be in September or October, when we have the opt-in period. I don't know. I don't know what I am going to do. So if you are confused, I am confused.

And one last comment about I think the future of our country rests in the education system that we have, and today education debt, student debt exceeds credit card debt in this country. It is a humongous problem. The affordability of an education for kids—when I went to school, it was amazingly affordable. Today it is not. You all do a great job here in North Carolina. I asked about your fees. It is less than \$1,000 per semester. That is still affordable in today's dollars.

So, thank you all, all the panel. Great job, and I will now excuse you all and we will have our second panel come up.

I would like to call the committee back to order. I would like to again thank the witnesses for taking the time to testify before the committee today, and I will now ask that the second panel come forward, which they have done.

It is again my pleasure to yield to Mr. Hudson to introduce our second panel of witnesses.

Mr. HUDSON. Thank you, Mr. Chairman.

First we have Mr. Dave Bass, who is the Vice President of Compensation and Associate Wellness at Delhaize America, headquartered in Salisbury. They employ many area residents in their Food Line grocery stores, which are very popular with me and a lot of folks around here.

Also, Mr. Ed Tubel is the Founder and CEO of Tricor, Inc., in Charlotte. Mr. Tubel operates a number of Sonny's Bar-B-Q Restaurant franchises—we frequent the one here at Exit 49 in this area—and he is a recipient of the North Carolina Small Business Administration Entrepreneur of the Year Award.

Dr. Olson Huff is a retired pediatrician from Asheville. He is a veteran of the United States Air Force.

We thank you for your service, sir.

He served as a flight surgeon in Vietnam. He received his medical degree from the University of Louisville.

Finally, Mr. Bruce Silver is the President and CEO of Racing Electronics in Concord. Racing Electronics is the worldwide leader in providing radio communication products to the motor sports industry, and you can rent those, I believe, at the track. I have done that myself. He was named the 2011 Small Business of the Year by the Cabarrus Regional Chamber of Commerce.

So, thank you all for being here.

Mr. Chairman, I yield back.

Chairman ROE. I thank the gentleman for yielding.

Before recognizing you, we will go through again the lighting system. You will each have five minutes to present your testimony. When you begin, the light in front of you will turn green. With one minute left, it will turn amber. Then when your time has expired, the light will turn red, at which point we will ask you to wrap up your remarks as best as you can. After everyone has testified, each member will have five minutes, and we probably again will have a second round of questioning.

I will now recognize Mr. Bass for your testimony.

**STATEMENT OF DAVE BASS, VICE PRESIDENT, COMPENSATION AND ASSOCIATE WELLNESS, DELHAIZE AMERICA, CONCORD, NC**

Mr. BASS. Thank you. Chairman Roe and Congressman Hudson, my name is Dave Bass, and I am the Vice President of Compensation and Associate Wellness for Delhaize America Shared Services Group, LLC. Perhaps as important, I am also a resident of Concord. In my role, I work on behalf of the companies of Delhaize America, including Bottom Dollar Food, Food Lion, Hannaford, Harvey's, Sweetbay Supermarket and Reid's, to understand and apply health and wellness best practices as it pertains to our asso-

ciates and our company. Thank you for the opportunity to appear here today to provide feedback on the implications of the Patient Protection and Affordable Care Act for Delhaize America's business.

Delhaize America is a leading supermarket operator in the United States, with over 105,000 associates working in 18 states throughout our network of 1,500 store locations, 10 distribution centers, and four corporate support centers. Despite the economic climate during the Great Recession and the narrow 1 percent profit margins traditionally associated with the grocery industry, in recent years our company has expanded into new markets and grown its Bottom Dollar Food banner in New Jersey, Ohio and Pennsylvania.

In North Carolina, Delhaize America employs over 30,000 associates and operates more than 500 store locations. As you may know, Food Lion was founded in Salisbury, North Carolina in 1957, and we are proud of our long history in this great state. In all of our operating states, our company is dedicated to supporting programs and organizations that make a difference in the lives of our shoppers and neighbors. Last year alone, Delhaize America companies donated over 41 million pounds of food. Through corporate and foundation giving, local programs and individual associate involvement, millions of dollars and countless volunteer hours are devoted to helping our communities and our associates grow and prosper.

Delhaize America's vision is to enrich the lives of our customers, associates, and communities we serve in a sustainable way. Along with a culture of respect, Delhaize believes a primary way of supporting our associates in a sustainable way is through the provision of benefits to a large number of our associates. To meet the needs of our associates and support their overall health and wellness, Delhaize America provides comprehensive health care coverage, one of the most expensive benefit options, for its associates. Delhaize is proud to offer all our full-time associates the opportunity to enroll in healthcare, and has done so for many, many years.

The Patient Protection and Affordable Care Act creates complex challenges for food retailers seeking to provide health care coverage to associates while maintaining a viable business in an exceedingly competitive consumer environment. Food retailers and their associates operate under fluctuating and unpredictable work schedules in order to meet varying consumer demand. Health coverage and compliance costs must remain affordable to Delhaize America in order for the company to maintain employee benefits and provide competitive consumer prices.

Under the Patient Protection and Affordable Care Act, beginning in 2014, large employers, those larger than 50 full-time equivalents, must offer coverage to full-time employees, which the law defines as averaging 30 hours or more per week, and that employer-offered coverage must be affordable, which is defined as not costing the employee more than 9.5 percent of his or her household income, and provide a minimum value of at least 60 percent of the average benefit costs covered or face a tax penalty, a mouthful. While on the surface this may seem straightforward, there are many com-

plications that could impact the health coverage that Delhaize provides.

As we look ahead to the implementation of the primary provisions of the Patient Protection and Affordable Care Act, our company foresees a number of challenges, and I would like to draw your attention to a few key issues for our business including: the definition of a full-time employee; affordability criteria; mandatory auto-enrollment; the temporary reinsurance fee; and Flexible Spending Account purchases.

Under the Patient Protection and Affordable Care Act, as a large employer, Delhaize America must offer coverage to full-time associates who average 30 hours per week beginning in 2014. The companies of Delhaize America employ a significant number of both full-time and part-time associates. Currently, 45 percent of our associates are in full-time hourly and salaried roles. Both full-time and part-time associates who meet eligibility criteria are able to receive coverage under our medical plan. Full-time hourly, salaried, and part-time associates working at least an average of 35 hours per week are eligible for coverage after two months of continuous employment.

I will skip ahead here a little bit.

Mandatory auto-enrollment. Delhaize America also is concerned about the Affordable Care Act's mandatory auto-enrollment provision. Open enrollment for Delhaize America's medical plan is held annually in October and November to give associates an opportunity to select coverage options for the next plan year. Associates with existing coverage under the company's medical plan that do not actively engage in the enrollment process for benefits have their benefits rolled over to their existing selections.

The Affordable Care Act's mandatory associate enrollment provision under Section 1511 could inadvertently cost associates wages and create duplicative coverage if a parent or spouse already covers the insurance.

To wrap up here today, as an employer and retailer who is trying to do the right thing by continuing to offer coverage to our full-time employees, I am concerned that even if I were to have the perfect playbook to try to make sure I have all of my full-time equivalents identified and I have offered the right coverage, my company may still get penalized because one of our employees is mistakenly awarded an ACA credit. I am either going to be in a position of demonstrating that we did offer affordable coverage and have that person, that associate, penalized, or Delhaize America is going to get penalized.

Any steps that can be taken by the committee to mitigate the burdens employers are facing is greatly appreciated. Specifically, we need Congress' help in addressing some of these burdens that puts at risk our company's ability to offer health coverage that is affordable and of value to as many of our employees as possible.

Representative Roe and Representative Hudson, thank you for your time.

[The statement of Mr. Bass follows:]

**Prepared Statement of Dave Bass, Vice President, Compensation and Associate Wellness, Delhaize America Shared Services Group, LLC**

Chairman Roe and Congressman Hudson, my name is Dave Bass, and I am the Vice President of Compensation and Associate Wellness for Delhaize America Shared Services Group, LLC. Perhaps as important, I also am a resident of Concord, North Carolina. In my role, I work on behalf of the companies of Delhaize America, LLC, including Bottom Dollar Food, Food Lion, Hannaford, Harveys, Sweetbay Supermarket and Reid's, to understand and apply health and wellness best practices as it pertains to our associates and our company. Thank you for the opportunity to appear here today to provide feedback on the implications of the Patient Protection and Affordable Care Act for Delhaize America's business.

Delhaize America is a leading supermarket operator in the United States, with over 105,000 associates working in 18 states throughout our network of 1,553 store locations, 10 distribution centers and four corporate support centers. Despite the economic climate during the Great Recession and the narrow one percent profit margins traditionally associated with the grocery industry, in recent years our company has expanded into new markets and grown its Bottom Dollar Food banner in New Jersey, Ohio and Pennsylvania.

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Delhaize America's vision is to, 'Enrich the lives of our customers, associates, and communities we serve in a sustainable way.' Along with a culture of respect, Delhaize believes a primary way of supporting our associates in a sustainable way is through the provision of benefits to a large number of our associates. To meet the needs of our associates and support their overall health and wellness, Delhaize America provides comprehensive health care coverage, one of the most expensive benefit options, for its associates. Delhaize is proud to offer all our full-time associates the opportunity to enroll in healthcare—and has done so for many, many years.

Challenges Facing Delhaize America and its Associates under the Affordable Care Act The Patient Protection and Affordable Care Act creates complex challenges for food retailers seeking to provide health care coverage to associates while maintaining a viable business in an exceedingly competitive consumer environment. Food retailers and their associates operate under fluctuating and unpredictable work schedules in order to meet varying consumer demand. Health coverage and compliance costs must remain affordable to Delhaize America in order for the company to maintain employee benefits and provide competitive consumer prices.

Under the Patient Protection and Affordable Care Act, beginning in 2014, 'large employers' (which the law defines as companies with 50 or more full-time 'equivalents') must offer coverage to full-time employees (which the law defines as averaging 30 hours/week) and that employer-offered coverage must be 'affordable' (defined as not costing the employee more than 9.5% of his/her household income) and provide a 'minimum value' of at least 60% of the average benefit costs covered or face a tax penalty. While on the surface this may seem straight-forward, there are many complications that could impact the health coverage that Delhaize provides.

As we look ahead to the implementation of the primary provisions of the Patient Protection and Affordable Care Act, our company foresees a number of challenges, and I would like to draw your attention to a few key issues for our business including: the definition of a full-time employee, affordability criteria, mandatory auto-enrollment, the temporary reinsurance fee and Flexible Spending Account purchases.

*The definition of a full-time employee*

Under the Patient Protection and Affordable Care Act (ACA; PL 111-148), as a large employer Delhaize America must offer coverage to full-time employees who average 30 hours per week beginning in 2014. The companies of Delhaize America employ a significant number of both full and part-time associates. Currently, 45 percent of our associates are in full time hourly and salaried roles. Both full and part-time associates who meet eligibility criteria are able to receive coverage under our medical plan. Full-time hourly, salaried and part-time salaried associates working at least an average of 35 hours per week are eligible for coverage after two months of continuous employment.

The revised definition of a full-time employee under the Affordable Care Act could result in the reclassification of many of Delhaize America's associates from part-time to full-time. Such a change may impact store managers' ability to provide for flexible scheduling, and associates' hours could be impacted as a result. The definition of a full-time employee under the Act also may cause confusion among associates as they seek to understand which benefits they are eligible to receive should the individual only be considered full-time for the purposes of medical coverage.

#### *Affordability criteria*

Another complicating factor is that when coverage is offered to our associates, the premium must not cost the associate more than 9.5% of his/her household income and also must cover at least 60% of the average benefit costs. Again, while that may sound simple, it is challenging to analyze associate wages even under the current safe harbor provisions that allow employers to use an employee's W-2 wages to verify affordability.

Complicating matters, as I am seeking to define Delhaize America's health plan and determine associate rates for 2014, the uncertainty created by the federal government's delay in rule finalization affects my ability to understand how best to craft and comply with the Affordable Care Act as I look to finalize our company's plan for next year.

#### *Mandatory auto-enrollment*

Delhaize America also is concerned about the Affordable Care Act's mandatory, auto-enrollment provision. Open enrollment for Delhaize America's medical plan is held annually in October and November to give associates an opportunity to select coverage options for the next plan year.

Associates with existing coverage under the company's medical plan that do not actively engage in the enrollment process for benefits have their benefits rolled over to their existing selections. Allowing for the automatic enrollment of associates who have previously chosen to receive coverage saves associates time and ensures continued coverage.

Whereas, the Affordable Care Act's mandatory associate enrollment provision under Section 1511 could inadvertently cost associates' wages and create duplicative coverage if a parent or spouse already covers the associate. When associates who do not want employer coverage fail to opt-out of the auto-enrollment process, the employer is required to deduct a premium from the associates' paycheck. Delhaize America supports Congressman Hudson's introduction of the Auto Enroll Repeal Act (H.R. 1254) that would repeal the Affordable Care Act's mandatory enrollment provision, helping to ensure that associates take an active role in coverage determinations.

#### *Temporary reinsurance fee*

On top of all the compliance costs associated with offering health coverage under these rules is a 'temporary' reinsurance fee for employers offering self-insured plans that will charge our company \$5.25 per month per capita in benefit year 2014 (\$63 per capita for all of 2014) and onward.

#### *Flexible spending account purchases*

Additionally, under a little known provision of the Affordable Care Act, Flexible Spending Account (FSA) and Healthcare Reimbursement Account (HRA) funds may no longer be used to buy over-the-counter (OTC) medicines unless they are prescribed by a doctor. This prohibition restricts individuals' access to OTC medications by requiring an unnecessary and more costly visit to the doctor's office for an OTC prescription while also putting our store locations without pharmacies at risk of losing FSA shoppers. It was just five years ago, in 2008, when Food Lion retrofitted its registers to comply with Internal Revenue Service regulations to accept customers' FSA/HRA cards for approved healthcare and pharmacy items.

Many of our customers rely on over-the-counter medicines to manage existing conditions, and Delhaize America supports legislation that would reinstate FSA/HRA purchases of over-the-counter medicines without a prescription. In the 112th Congress, the Restoring Access to Medication Act (H.R. 2529) was introduced to restore this valuable benefit, and we would encourage the committee to evaluate options for the introduction of similar legislation in the 113th Congress.

#### *Conclusion*

Since the Affordable Care Act became law, I have been focused on trying to understand all of the applicable rules so we can determine how our companies' health plans fit into this structure. I understand that the Administration has attempted to provide some flexibility to employers, but many of these rules were only recently

released and many rules are still pending. As a human resources professional, I cannot afford to build a health plan based on so many uncertainties, particularly given the complexities of these rules. Unfortunately, there is no one place or handbook that is available for me to figure out all of the rules and ensure that our plan is in place and our employees understand their options—as the need to finalize my plan design quickly bears down on me.

As an employer and retailer who is trying to do the right thing by continuing to offer coverage to our full-time employees, I'm concerned that even if I were to have the perfect playbook to try to make sure I have all of my FTEs identified and I have offered the 'right' coverage, my company may still get penalized because one of our employees is mistakenly awarded an ACA tax credit. I'm either going to be in a position of demonstrating that we did offer affordable coverage and have that person—that associate—penalized or Delhaize America is going to get penalized.

Any steps that can be taken by the Committee to mitigate the burdens employers are facing is greatly appreciated. Specifically, we need Congress's help in addressing some of these burdens that puts at risk our company's ability to offer health coverage that is affordable and of value to as many of our employees as possible. First, we need Congress to amend the ACA's full-time employee definition to be in line with current workforce standards. Second, employers need a 'transition' or 'good faith' period through 2014 to figure out all of these rules, test how our eligibility measurements and health plans perform without fear of being penalized—and our associates to similarly understand what is available to them. And as a retailer, we need Congress to restore the use of Flexible Spending Account debit card purchases without a prescription. By no means are these suggested reforms 'cure-alls,' but the changes would potentially alleviate some of the burdens to our business.

Delhaize America is grateful for the opportunity to appear before you today. We welcome the opportunity to work with you in your efforts to address and clarify provisions within the Affordable Care Act.

Representative Roe and Representative Hudson, thank you for your time.

Chairman ROE. Thank you, Mr. Bass.  
Mr. Tubel?

**STATEMENT OF ED TUBEL, FOUNDER AND CEO,  
TRICOR INC., CHARLOTTE, NC**

Mr. TUBEL. Chairman Roe, Congressman Hudson, thank you for this opportunity. My name is Ed Tubel, and I am Founder and CEO of Tricor Inc., a licensed franchisee of Sonny's Real Pit Bar-B-Q. Today I will attempt to provide a realistic overview in regards to the impact the Affordable Care Act has on my small business.

I was fortunate to start Sonny's in the Carolinas in 1978 with an SBA guaranteed loan. Over 34 years, we have built 27 restaurants in four states. We currently operate five locations in North and South Carolina and employ 178 full and part-time people. Tricor/Sonny's has a very strong reputation locally as a family restaurant that provides for both our customers and our people.

Our current health program is an HRA and a mini medical where we contribute to our 75 full-time and 103 part-time workers.

Operating under the Affordable Care Act has negative consequences on our company. In essence, it is really not affordable.

Since its passage, we have studied and participated in numerous seminars to estimate our most realistic cost in implementing this program. Based upon this information, it would cost our company from \$140,000 to \$200,000 to meet this mandate. This is disastrous financially since we are only projecting 2013 net profit of \$240,000.

Our loan covenants require us to maintain a coverage ratio of 1.5 to 1. This burdensome cost would reduce our coverage ratio to below 1, thereby placing our loan in default. Our bank could either increase our interest rate by adding to our costs, call our loan,



which is absolutely unaffordable, or allow us to remain in default. I believe we all know the current financial atmosphere of the banking industry today.

We have evaluated our choices to abide by the law as presently interpreted to include, one, increasing our menu prices to cover the additional costs, making us less competitive and affecting our sales, which eventually could lead to losses. The restaurant industry is very competitive and has experienced a very traumatic down slide since 2008. Research by the National Restaurant Association shows that since the recession, 70 percent have changed their eating-out habits by either reducing or even eliminating dining out. Increasing menu prices would be my last resort.

We could reduce scheduled hours of 30 employees to less than 29, reducing our people's hours and income and the resulting effect on the local economy. This could require valuable employees to either obtain a second job or quit and seek full-time employment elsewhere.

Split the company into four or five companies with different ownership is another option in order to stay under the 50 full-time requirements. This is difficult, and also costly.

Or finally, we could just pay the penalty for not providing coverage under the Affordable Care Act.

Major companies have legal advisors who will successfully guide them through this legislation. Small businesses such as ours must obtain as much information as possible and do their best to live by the letter of the law. Even after attempting in good faith to abide by the law, because this act is so complicated, we hope and pray we do not get penalized.

The majority of our employees are below the age of 40. Many are students attending local schools, working during breaks and holidays part-time to supplement their income. The restaurant business has a history of high turnover due to this nature of being a second occupation, a supplement for school, or even a beginning job. Using W-2s to compute the total number of full-time equivalents under this mandate would unfairly influence these results. In addition, the majority of our full-time employees believe this healthcare will be free. Many mistakenly believe the 9.5 percent cost is coming from Tricor rather than required from them, which many cannot afford, not to mention the administrative nightmare of our small company just having to enforce.

Finally, we invest the majority of our cash flow into updating and remodeling our facilities to try to stay competitive. However, current profit levels are not sufficient to allow us to remodel or even consider expanding, which could provide an additional 50 jobs per location.

The information I provided to you today is our best indications of observing the Act. We respectfully request that Congress reevaluate this mandate in relation to small business concerning both the 50 full-time threshold and calculation of full-time equivalents. With new interpretations being issued regularly, we can only hope and pray that we will be able to sustain our 34-year-old business and survive for both our employees and our customers. Thank you.

[The statement of Mr. Tubel follows:]

**Prepared Statement of Edmund Tubel, CEO, Tricor Inc.,  
Licensed Franchisee, Sonny's Real Pit Bar B Q Restaurants**

Ladies and Gentlemen: My name is Edmund Tubel and I am CEO of Tricor Inc a licensed franchi see of Sonny's Real Pit Bar B Q Restaurants.

Today I will attempt to provide as objective a position in regards to the impact the Affordable Care Act has on a small business such as our company.

I was fortunate to start Sonny's in the Carolina's in 1978 with an SBA guaranteed loan. Over 34 years, we have built 27 restaurants in four states. We currently operate 5 locations in North and South Carolina and employ 178 full and part-time people. Tricor/Sonny's has a very strong reputation locally as a family restaurant that provides not only for their customers but also their own people.

Our current health program is an HRA and a mini medical where we contribute to both our salary and hourly employees.

Our census includes 75 Full time and 103 part time workers with less than 30 hours per week.

Our interest today is to illustrate not only the complexity of operating under this legislation but also the negative consequences the Affordable Care Act will have on our Company. In essence it's really not affordable.

Since its passage, we having observed and studied various outlines and participated in numerous seminars, to develop our best estimate in implementing this program as currently outlined. Based upon this information, it would cost our company anywhere from \$150,000-\$200,000 to meet this mandate. This is disastrous financially since we are only projecting 2013 net profit of \$240,000.

Our loan covenants require us to maintain a coverage ratio of 1.5 to 1. This burdensome cost would reduce our coverage ratio to below 1 thereby placing our loan in default. Being in default would require the bank to 1) increase our interest rate, adding to our costs, 2) calling our loan, or 3) allowing us to remain in default. I believe we all know the current atmosphere of the financial community.

Therefore we have evaluated our choices to abide by the law as presently interpreted. These include:

1. Increasing our menu prices to cover the additional costs thereby making us less-competitive in the marketplace and affecting our sales which eventually could lead to losses. The restaurant industry is very competitive and has experienced a very traumatic downward slide since 2008. Research shows that since the recession 70% of people have changed their eating out habits by reducing or even eliminating dining out according to the National Restaurant Association. Increasing menu prices should be a last resort.

2. Reduce scheduled hours to less than 29 in order to stay below the 50 full time employee equivalent, thereby reducing our people's hours and income and the resulting effect on the local economy.

3. Split the company into 4-5 separate companies with different ownership in order to stay under the 50 full-time requirements.

4. Or just pay the penalty for not providing coverage under the Affordable Care Act.

Major companies I am sure have legal advisors that will successfully guide them through this legislation. Small businesses such as ours must obtain as much available information as possible and do their best to live by the letter of the law. Then because this act is so complicating hope and pray we do not get penalized.

Many of our employees are very young. Many are students attending local schools working during breaks and holidays part-time to supplement their income. The restaurant business understandably has a history of high turnover due to its nature of being a second occupation or a supplement for school or even a beginning job position.

Therefore using W-2's to compute the total number of those full time equivalents under the mandate would unfairly influence these results. In addition, the majority of our FTE employees will not be able to afford this healthcare. Not to mention the administrative nightmare of our small company having to enforce.

The information provided today is our best indications of observing the act. We respectfully request that Congress reevaluate this mandate in relation to small business concerning both the 50 fulltime threshold and calculation of full time equivalents.

With new interpretations being issued regularly we can only hope and pray that we will be able to sustain our 34 year old business and survive for our employees and customers.

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Chairman ROE. Thank you.

Dr. Huff, thank you for your service to our country.

**STATEMENT OF OLSON HUFF, PEDIATRICIAN, ASHEVILLE, NC**

Dr. HUFF. Good morning and thank you very much for allowing me to be here today, Chairman Roe and Congressman Hudson. I think that we are an example of democracy at its best, and I really appreciate the opportunity of sharing in that with you.

I have to say, however, as a pediatrician, Chairman Roe, I may need to talk to you afterwards about some of those 5,000 children you gave me to help take care of during these years. [Laughter.]

Chairman ROE. Well, Dr. Huff, they are all good Republicans. [Laughter.]

Dr. HUFF. I really appreciate the fact that we are in this discussion, and in the many years, 50 or more now, that I have been in medical practice in North Carolina and in other parts of the world, I have dealt with countless families. I have seen them at their best, and I have seen them at their worst.

There are three things that I have noticed about the families and the children I have cared for which is certainly common to all of us. Number one, when we are sick, we want to get well. Number two, when we are injured, we want to be mended. And number three, when we have pain, we want relief. That basically is the scenario that has been handed to me as a medical professional and to all of those who are my colleagues: How do we respond to those particular issues of health?

My perspective from this presentation that I want to make to you this morning comes not from a particular business or an institution to which I may belong, but from the representation that I hope that I have to say about the health of all of our people.

As a practitioner, I have been faced over these 50 years with a magnificent amount of change. We have seen changes in technology, we have seen changes in the scientific advances, and we have seen changes in how we become educated about those. As a result, we have increased the cost of medical care significantly in order to respond to those changes. That cost has been shared by patients, it has been shared by payers, it has been shared by private and by public institutions.

One of the things that I remember specifically as a young patient of mine by the name of Alice, she has cerebral palsy. She came into my clinic always with a bright smile and a high-five for everyone. I asked her mother one day, "What do you need to make sure that Alice gets the best care?" She said, "I need to make sure that someone is taking care of her who knows their business. I need to get as much of the care for her in one place, and I need to make sure that it is covered by some way, that it is paid for, so I can get her the care she needs."

That is the question that is in front of us, and I want to give two very specific reasons that I feel it is important to answer Alice's mother.

First of all, North Carolina has missed a major opportunity when it failed to expand Medicaid, a portion of the Affordable Care Act that would extend care to significant numbers of people that would increase their opportunity for preventive health care. In North Carolina, we lost 25,000 jobs. We failed to add to our gross domes-

tic product over the next 10 years, at least \$1.2 billion. But more importantly, we failed to ensure and guarantee that access to the relief of pain, the relief of sickness and the mending of bodies that are broken for 500,000 people.

Translate that into another factor. We have about 122,000 births in North Carolina each year, and almost 10 percent of those are born too early. The premature birth rate at our hospital costs us a little over \$10,000 a year, compared to under \$2,000 a year for a full-term newborn baby. We can prevent prematurity by offering better resources for preventive health care, and Medicaid is one of the ways in which women can get that preventive health care.

We have talked a lot about cost today, and we will continue to talk about cost as it is related to health care. One of the things, however, that I think is tremendously important for us to understand is that there is a return on investment here, and rather than spending so much time on cost, I would love to see us spend more time on the benefits of what it means to insure all of our people and guarantee them the relief that is so necessary that we practitioners, hospitals, and institutions of medicine need to provide.

Thank you for your service to our country. I continue to hope we will dialogue about this together.

[The statement of Dr. Huff follows:]

#### **Prepared Statement of Olson Huff, M.D., FAAP**

For more than thirty-five years I have provided health care to countless children in North Carolina and have entered the lives of their families in substantial and enduring ways. I have seen them at their best and their worst. In those years, I have learned many things. Three stand out:

1. When ill, there is a desire to be well.
2. When injured, there is a desire to be mended.
3. When in pain there is a desire for relief.

My task as a medical practitioner has been to address those issues and to bring a resolution to those desires whenever and wherever possible. To do so required me, and all my fellow medical colleagues, to rely on an extensive network of health care resources. Chief among those resources is and has been the economic strength necessary to support an ever-expanding medical system engaged in technological, scientific and educational advances.

From my perspective as a medical practitioner, I wish to address two specific issues affecting children and their families in North Carolina and the economics surrounding them.

They are:

1. Medicaid Expansion
2. Premature births

Let me first state that these two issues are only a fraction of the many faces of health care today and both are centered squarely in the center of preventive care, a must if health care costs are to be reduced.

Medicaid expansion in North Carolina. This opportunity of the ACA would have produced 25,000 jobs in North Carolina, added between 1.2 and 1.7 billion dollars to the GDP of the state and provided badly needed health care access to 500,000 uninsured citizens. This would have been a bold step for prevention as the most reliable index of better health and therefore decreased medical costs is reliable access to health care.

Premature births. In North Carolina each year, approximately 122,000 babies are born. At the last counting, 15,569 of those were born too early. Not to even mention the human cost and impact on the economic and emotional health of a family with a premature baby, the average cost of caring for that baby is about \$50,000.00 compared to \$4550.00 for a full term healthy infant.

The figures speak for themselves. Improved access to care, and a reliable resource to pay for it yields better health, better prenatal and infant care, a lowered rate of premature births and a healthier and more dependable work force to drive the engines of commerce our state so badly needs.

Expanding Medicaid is one easily achievable way to guarantee that access to a population most likely to benefit and thus most likely improve the economic bottom line that will add greatly to the future needs and development of all of North Carolina's citizens.

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Chairman ROE. Thank you, Dr. Huff.  
Mr. Silver?

**STATEMENT OF BRUCE SILVER, PRESIDENT AND CEO,  
RACING ELECTRONICS, CONCORD, NC**

Mr. SILVER. Thank you. My name is Bruce Silver. I am the President and CEO and Founder of Racing Electronics. We are based in Concord, North Carolina. I am very proud to be here today, and I want to thank the Congressman Hudson and Chairman Roe for allowing me to speak today.

As a small business owner, I am concerned about the effects of the Affordable Health Care Act, Obamacare, and how it affects me and my small business in the future.

What was once a choice for Americans will now become mandates and requirements, not only for employers but for also employees. Our right to choose is going to be lost.

Insurance companies have already seen new taxes on health care. These new taxes are already in place and already have increased our premiums. In 2012, our premiums at Racing Electronics rose by 28 percent. In this year of renewal, just this month, in April of 2013, we have seen a 40 percent increase this year to our health care premiums. We cannot continue to sustain this and absorb increases and the effects to our bottom line.

In the past, we have increased our employees' share of their paying for their health coverage, increased co-pays, and increased their deductibles. As a net result, our employees enjoy a much less rich plan than they enjoyed just three years ago.

In the past we have competed in the marketplace, and still currently to this day we compete in the marketplace for employees. We have job applicants who come in wanting to know what our salary is, what their vacation time is, and what their insurance plan is. We compete by having affordable health care for our employees, by having substantial and equitable salaries to offer our employees. That choice for health care is being taken away. We can't compete with that now. It is going to be mandated what we are going to have to give.

We are looking for automated distribution. We distribute radios and scanners at the Nascar and Indy Car and NHRA races, mostly all over the USA. This week in Talladega, we will have 40 staff members. I am sure you have all seen the high-tech vending machines that have started to come to airports and malls around the country. We are looking at that right now. We are looking at what the benefits are if we would go and have 30 machines instead of 30 staff members at the race, and the result—we don't want that result, we don't want that result.

Since moving our headquarters to Concord in 2005, we have started to re-hire North Carolinians and put people back to work. While based in New Jersey in the early 1990s, we moved some of our production to Asia. I am very proud that we are pulling back

a lot of that production and putting people back to work in this country. Thank you.

[The statement of Mr. Silver follows:]

**Prepared Statement of Bruce Silver, President, Electronics Industries Corp.—TIA Racing Electronics**

*Talking Points*

- Taxes Accessed to Healthcare Providers—How this affects premiums
- New Mandates—The effect of mandates related to premium hikes First year and future year costs (unknown)
  - The disincentives for businesses to hire—
    - Avoid penalties, new costs and burdens
    - Turning to outsource work and turn to contractors and not hire new employees
  - The elements regarding hiring/retention of employees (most desirable candidates)—Government in independent business
  - The effects on companies of 50 or more employees—How part-time/seasonal employees will be classified and the affects
  - Related Penalties/Calculations—
    - Tax affects
    - How much penalty payments will generate What plans the employer may be required to offer
    - Calculations of the employee contribution as it relates to the household income
    - Why the premiums will continue to soar and the effect on employee's rising deductibles and out of pocket expenses

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Chairman ROE. Thank you, Mr. Silver, and thank the panel for your testimony, all again very good.

In the right of full disclosure, the staff and I ate at a Sonny's Restaurant last night, and we are still full. It was very good. [Laughter.]

Chairman ROE. We know a little something about Nascar racing in East Tennessee at the Thunder Valley and the Bristol Motor Speedway, so we use your products there.

Mr. SILVER. Thank you.

Chairman ROE. We thank you for that, and we would like to see, of course, that business get back on its feet a little bit, too. They have been struggling a little bit, the racing industry has.

Let me start by saying that I share a vision and a goal, and one of the reasons I left my medical practice and I told my wife I am either going to quit complaining or I am going to try to get elected to Congress and do something about the way I think the healthcare system is going in this country. I could see in my own patients this cost forcing people to lose their insurance, and you have seen this recession do that. We have fewer people now that have private health insurance coverage than before. So we have lost coverage because of our economy, and we are not going to increase coverage by losing jobs. We increase it by, as you, Mr. Silver, pointed out, bringing that manufacturing back, allowing people to get jobs and fill these positions that have health insurance coverage.

And I went through this health care reform in Tennessee and I watched what happened, and I can see the same thing happening here on a national level. We have created a massive bureaucracy for the simplest transaction in the world, and that is a patient coming to see me and me getting paid for that transaction. It is unbelievable when you listen to all of the work that has to be done for that to happen now, and we have only begun to scratch the surface. We haven't even talked about Medicare, which is extremely impor-

tant for me and extremely complicated when you look at the Affordable Care Act.

So let me just talk about Medicaid expansion. Our state in Tennessee elected not to do it, to expand, and elected not to have the exchange. The Federal Government will set up the exchange. Let me just explain to you why we elected not to do it.

Our governor, Governor Haslam, what he wanted to do was to have the flexibility to allow patients on Medicaid—by the way, if you want to, go pull this up. A large study was just published by the University of Virginia, 800,000-something patients, not a small study. Medicaid patients' surgical outcomes were worse than people that did not have health insurance coverage at all. The outcomes were worse. Mortality was higher and so forth. Why do we take a flawed, failed system that doesn't serve the patients well, why don't we reform that system so that it serves them better?

One of the things I think we can do with that is to allow the private market to work. The public it has served, and, Dr. Huff, in Tennessee, all women who don't have health insurance coverage—because pregnancy is one of the things where you is or you ain't. So it is not one of those things where I may be pregnant. So in Tennessee, we cover every pregnant woman. So they have access to coverage. And with SCHIP plan, all of our children have coverage for pediatric coverage. So that is happening right now in our state, and I would suspect a lot of it is happening here.

What you are talking about is expanding the program to the uninsured in North Carolina, and I think certainly those folks need to have adequate coverage, but there is a better way to do it other than Medicaid. What we wanted to do is use the same good health insurance that I currently have, I would like to have lower-income people have access to that, and that is what we would like to do in Tennessee.

Mr. Bass, I am going to ask you a couple of questions. It is extremely important what you brought out in your testimony, which was excellent. One was defining a 40-hour work week. I think that is very important. Two is would you go over, Mr. Bass, a good-faith effort you were talking about in 2014? And lastly, a lot of people don't pay any attention to it, but it would help to fund the Affordable Care Act. To me, it was exactly the wrong way to go, to take a flexible spending account that I have right now and have me call my doctor to be able to get Prilosec over the counter instead of using your flexible spending account. You send it to the highest-cost provider instead of just letting me go down and get my Prilosec.

And by the way, this is a personal testimonial. Thirty-one years I have practiced medicine, took care of some of the sickest people in the world. I never took a Tums, and six months after getting to Congress, I take a Prilosec every day, to let you know how it is. [Laughter.]

So if you would go over those three points I made?

Mr. BASS. Sure can. Food Lion invested itself several years ago to support the IRS regs around over-the-counter medications and accepting FSA accounts, and obviously with the new laws, that investment is going to be in jeopardy. We would similarly argue that we think it is inefficient to have patients go to their doctor for over-

the-counter medications that they should be able to buy via those accounts without that interruption, I would argue.

As far as a full-time associate, we strongly believe that for us, 35 hours and up is an adequate definition, and we believe that the expansion of that to 30 hours will create confusion, added cost, and in a business, frankly, where everyone sells food, we are doing our best to serve our customers and our associates in the best way possible. So for us, that expansion is really something that is important to us, and we believe we should be re-examining that.

Chairman ROE. One of the things that I wanted to bring up that I learned in a hearing in Evansville, Indiana, obviously in medicine, we don't do this this way, but it is profit per employee. We had an IHOP owner that owned 12 IHOPs, had 800 employees, and he said he was very efficient. He made \$2,800 per employee, and apparently in that business, that is very good. I didn't know that. Other McDonald's franchisee owners told me that \$1,200 a year was very good per employee.

He said, Doc, what do I do? He said, if I pay for the health insurance that I am required by the government, the essential health package, essential health benefits it is called—the government decides what you buy, not you, and what you can afford. He said, it is going to cost me \$8,000. I am upside-down \$5,000 per employee. If I pay the penalty and the taxes on that, I make no money. He said, what do I do? I said, well, by Washington speak, you charge me \$10 for a pancake and you go out of business. I think that is exactly what you just described. I think I heard you say the last thing you wanted to do was raise the price for your customer.

Mr. TUBEL. Exactly.

Chairman ROE. Could you comment on that?

Mr. TUBEL. Well, one of the problems we have is that we compete in a very competitive marketplace to where we compete with a lot of mom and pops. They won't have to operate under the same mandate as we do, which would require us, if we raised our prices, to go across the street and get something for a lot less money than coming to us, notwithstanding the service or the quality of what we provide.

But bottom line is, after all is said and done, we are lucky at the end of the day to, after taxes, to make 2 to 3 percent profit, which is more in line with about \$1,200 per employee.

Chairman ROE. I thank you.

I yield to Mr. Hudson.

Mr. HUDSON. Thank you, Mr. Chairman.

I thank the witnesses for your testimony.

Going back, Mr. Bass, talking about I guess these added costs, which I think Mr. Tubel is referring to, how is your business going to respond? You are operating on a 1 percent profit margin on grocery items already. Are you going to raise food prices? Do you impact the incomes of employees? Your organization does a tremendous amount of charitable work in the community. Is that where we will probably see the cuts? How are you going to respond to the costs that are coming down the pike?

Mr. BASS. That is a great question and the key one that we are wrestling with right now. So for us, we are deep in the planning phase. I think, as was mentioned on the earlier panel, with many



new laws, we spend a fair amount of money, frankly, both for legal advice and for consulting advice, which could be used to grow our business in different ways, serve our customers differently and, frankly, serve our associates.

We have already spent a substantial amount of money to try and determine how to comply with the regulations that are there already. So going forward, we continue to do that work. We are not quite sure exactly what the full impact will be. But as a competitive business who also believes we need to serve our employees as much as we serve our customers, we have a real strong conviction to continue to maintain health insurance. The form that it happens, the full impact of that, we are not quite sure, but it is very complex, and that is really why I think we need to consider some of the additional changes to those laws that have been discussed already.

Mr. HUDSON. I appreciate that.

Mr. Tubel, you talked about the impact on your profit margins. I don't think folks who are not in business and, unfortunately, the people who are writing regulations for laws like this understand just how tight business people operate on margins, and especially in economies like this.

You mentioned, I believe, how much time you are having to spend on legal advice and that sort of thing. What is the impact of that, just trying to understand the law, trying to figure out how to comply with the law? What kind of impact does that have on you?

Mr. TUBEL. Well, what we try to do is participate in various seminars that are provided by the industry. The North Carolina Restaurant and Lodging Association has also brought us a seminar, and then our franchise company has brought in legal to try to separate the single operator to the mini operator to the big operator. So it takes time away.

But our biggest concern is if we get to the point where we can understand where we are at in the law, that it changes again. It is like a moving target for us. So we try to keep that moving target within range so we know that we have a probability of meeting the demands of the Act.

Mr. HUDSON. I know it is frustrating. I continue to try to beat that drum when we go to Washington just about what the uncertainty does to business people like yourself. So I will continue to be your advocate.

Mr. Silver, thank you for your testimony. Can you elaborate a little bit on what you mentioned just in terms of the health care cost as a disincentive for hiring folks like you?

Mr. SILVER. Sure. Right now, we have offered a very healthy, rich plan, didn't try to incentivize people coming on board and working for our company. We are going to have to limit that. We are going to have to back down on some of the coverage and, frankly, we feel we're going to lose some employees to other employers because we are not going to be able to sustain the level of health care that is going to be mandated.

Mr. HUDSON. Well, you have certainly been a great citizen of this community, as was recognized by the Chamber, recognized U.S.

Business of the Year, and we appreciate what you do for the community and the type of quality jobs you provide.

Mr. SILVER. Thank you. I am honored.

Mr. HUDSON. In my opinion, the Federal Government ought to be doing everything we can to get out of the way of people who are manufacturing things in this country, and we hope you can continue to have real people handing me a scanner at the race and not a machine.

Mr. SILVER. That is our goal. It will be a sad day for me and my company if we ever have to really go down that route.

Mr. HUDSON. Yes, sir. Well, as we look at just sort of what is the impact on your business, what do you think is the greatest impact out of this law as we look at ways we might improve it and tweak it? What is sort of the biggest thorn, the biggest burr in your saddle there?

Mr. SILVER. The lack of choice. We don't have a choice. We are told what we need to do. We are told how we need to do it. Instead of letting business do what businesses do and compete in the marketplace with good products and for good employees, we are told that we can't do that anymore. More regulation is not healthy for business.

Mr. HUDSON. That is very well said.

Mr. Chairman, before I yield back, during our break one of our citizens in the audience grabbed me and handed me an article about—it is titled, "Republicans and Democrats in Washington Conspire to Exempt Themselves from Obamacare," and I just wanted to state on the record that I have nothing to do with those negotiations, and as far as I am concerned we need to live under laws that we pass. So I don't support any efforts to exempt Congress, although I would love to find a way to exempt everyone from this health care law.

But with that, Mr. Chairman, I will yield back.

Chairman ROE. I thank the gentleman for yielding.

I had an email about that yesterday, and my response was I would vote against me if I did that. So I would vote against myself.

A couple of things that I want to sort of start by sharing with you to show you how complicated and complex this health care system this, and Dr. Huff brought it out. He spent his life taking care of poor children in western North Carolina, and that is a noble goal, something that just—literally across Mountain Sam's Gap is where I live. Medicaid is one way to do it. It was started in 1965, as Medicare was. Medicare began as a plan that cost \$3 billion, and the government in 1965, the government estimator said that in 1990, 25 years later, it would be a \$13 billion program, a \$12 billion program. It is \$110 billion. They missed it just a little bit, by a factor of nine.

Medicaid has had the same explosive growth. Over 40, 50 million people now have Medicaid in this country as their primary. And again, if it were a system that were working for them, that would be one thing. Because you get a Medicaid card doesn't mean you can get access to health insurance coverage. Our Medicaid patients tend to use more than the uninsured the emergency room, which is the most expensive, the worst thing you can do. And then there is the cost shifting that goes on. Let me explain what that is.

When you come in to the hospital or to the doctor's office, it pays, Medicaid pays less than 60 percent of the actual cost of providing the care. So that cost is shifted onto the private sector, forcing all of these gentlemen up here who provide health insurance coverage for their employees to go higher. So the government program is actually shifting the cost to the private sector, and let me give you an example.

When implantable defibrillators first came out, there was a man, a gentleman who needed one, and it was put in. Medicaid paid \$800 for that device. The only problem with it, it cost \$40,000. So that \$38,000, \$39,200—I am a public school guy; you see how I did in my math—that \$39,200 was shifted to private insurers. So we have to stop this cost shifting that is going on right now, currently. And remember that hospitals and doctors have the responsibility by the EMTALA law that anyone who comes up, whether you are legally in this country or illegally in this country, have a right to health care. If you show up in the emergency room, Dr. Huff will see you if he is on call. If you show up in the emergency room, I will see you, and we will treat you whether you can pay or not, and no one is complaining about that.

But we have to figure out a way to make this—as you heard these gentlemen say, their businesses can't afford it, and they can't afford more cost shifting. And it also occurs to a much lesser extent in Medicare.

So I am going to finish up my questions, and I certainly appreciate this panel. It has been very, very informative.

I think, Mr. Bass, you bring a point out that I had not thought of, which is the good faith period. I think we have to have a time, since I don't believe the Federal Government is going to be prepared for this come January 1, 2014, and it is the law of the land. I mean, it is the law we have to comply with and live with, and the thousands of pages somebody has to read. You guys are spending an inordinate amount of money and time doing that. Smaller businesses like these, they don't have an HR department to do that, so I don't know how they get the information. But we do need a grace period. I am taking that back. That is something I think we do.

And the question I have for all of you all, we have Secretary Sibelius in front of my committee on the 15th of May. If you had a question to ask her, what would you want me to ask? And I will take it back from right here and ask it.

Mr. BASS. I would emphasize a grace period that you just outlined. Food Lion and Delhaize America are proud to be strong partners in our communities. We will support both the law of the land and the desires of the communities we work within. We are proud to do that. We will do our best to comply with the law, but there are fairly strong penalties involved for lack of compliance that—we will not comply because we want to. We won't probably comply because we don't have the knowledge and skills yet. So if there were a grace period, that would be a huge plus from our perspective, and we would ask you to ask her that question.

Chairman ROE. And Secretary Sibelius is, by the way, for those of you in the audience who don't know, is the Secretary of Health

and Human Services, who is responsible for the implementation of the Affordable Care Act.

Mr. TUBEL. I think my question would be how do you apply one size to fit all? I mean, that is probably one of the biggest questions we have in health care, is that you can't put the one program in to cover everyone because everyone is different, and there should be some basis that you could allow some correction within the industry, based upon the industry demographics, to allow us to be able to afford the health care.

Chairman ROE. Dr. Huff?

Dr. HUFF. How do we provide incentives that are already part of the Affordable Care Act to increase the ability to make sure that primary care physicians are readily available in this country to take care of the people we need? Because we have a significant lack of primary care physicians, and part of the reason that we need health care reform is to make sure we incentivize the educational programs to make sure those persons are going to those areas of need.

Chairman ROE. Thank you, Dr. Huff.

Mr. Silver?

Mr. SILVER. I would challenge the Secretary to make this a good program, to implement changes that would not have the negative impact that they have now. It is beyond belief how complex, needlessly how complex this program has become, and that is my question.

Chairman ROE. We will pose those questions. And before I yield to Mr. Hudson for the last questions, Dr. Huff, just to let you know, there is a program in Medicare called Graduate Medical Education, GME. I am co-chair of the Academic Health Caucus in the Congress. What the Affordable Care Act did was in graduate—GME is graduate medical education—is how we train our young doctors across the country, and you are absolutely correct, we do not have enough. We will have, by 2025, 120,000 primary care doctors short in this nation, and we are going to be lined up around Wal-Mart to get in.

The Affordable Care Act cut the funding for graduate medical education so there is less money to train our residents. We are graduating more medical students, but they can't get into residency slots, and that is an impending disaster that we are working on.

Mr. Hudson, I yield.

Mr. HUDSON. Thank you, Mr. Chairman.

It was very enlightening to hear each of you say what you would ask the Secretary, and I think that is important. And again, I think that was part of the goal of this, was to allow real people to talk about real challenges out here in the real world. And so I appreciate your testimony and I appreciate those candid answers.

I guess I would just try to dig a little bit deeper on what are some of the things in each of your businesses that you do to control health care costs, and how does this law impact that. So what are some of the processes you go through, the decision-making you do currently to control costs, and then how does this law impact that sort of decision-making process? And I will just start with Mr. Bass.

Mr. BASS. For us, similar to other panelists, we have a significant emphasis on wellness. We do cover preventive care and the like, and we believe that that sets the stage for better long-term care and outcomes for the associate, as well as for us as a business, as well, on the cost side. There is a lot of uncertainty about exactly how wellness discounts work within the rate structure, and that is a significant question for us and, frankly, a concern, and that could dramatically impact how we offer wellness programs which, in the end, benefit the associate as much as it benefits our business.

Mr. HUDSON. Thank you.

Mr. Tubel?

Mr. TUBEL. Well, because of the nature of our business, we encourage our people to join the YMCA and the other fitness places around. We have a lot of time to group together and do it as teams, but we don't have anything formal within the actual restaurant itself.

Mr. HUDSON. Thank you.

I don't know if this question applies to your practice, but—

Dr. HUFF. Well, actually, I have in front of me my notepad that says, "Eat smart, move more, North Carolina." I think the things that you all are talking about that provide healthier ways of living is really a great emphasis.

I would like to mention one program in Greenville, South Carolina, and this is an OB/GYN program. Under the Medicaid program in South Carolina, they have actually taken pregnant women who are in the highest risk categories and reduced the premature birth weight by 47 percent. That is how we save money, and that is how we reduce costs, by really attending to those areas that are high risk and need attention to prevent it.

Mr. HUDSON. Mr. Silver?

Mr. SILVER. I am a small business. I started this out of my condominium in 1988 as a part-time job, and we kept adding and adding people. Two areas that I am a little sensitive to is weight and smoking, so I personally reward people that work within the company that quit smoking, financially, out of my own pocket, and lose weight for some people that we have had who had serious weight problems. We just preach a healthy lifestyle.

Mr. HUDSON. That is great. Well, I am impressed with your answers. But did any of you want to elaborate, though, on what the new health care law, the impact it will have on your ability to do some of these incentive programs? Is it going to be helpful, or is it going to kind of eliminate some of your flexibility to do these things? Anyone want to jump in? Mr. Bass?

Mr. BASS. Yes, I will jump in. I think that the key for us is that lack of clarity around the rate structure and discounts for wellness programs. At the end, we have so many dollars we can really spend on our benefits program. We are proud to do that. But to the extent that there is a lack of clarity and uncertainty, it puts us at risk of compliance, and the fines involved typically are much more expensive than some of the benefits involved. So it forces us into potentially making hard choices. We don't know where it is going to go quite yet as we gather all the information over the course of the summer. But there is a significant potential negative impact, I think, for myself and other large employers who are considering

the pros and cons of the rates, the regs, and the impact on wellness.

Mr. TUBEL. We would hope that the Affordable Care Act would provide some means for just about everybody to have the opportunity to be involved in the YMCA or a fitness center on a regular basis.

Dr. HUFF. And in relationship to prevention, again, North Carolina has drawn down several million dollars already from the Affordable Care Act to put into place prevention programs for obesity prevention, smoking prevention, and to increase activity. So there has been some effort that has been made under the Affordable Care Act for different states, certainly North Carolina, to benefit from some of the monies that can provide better prevention.

Mr. SILVER. We are going to continue to do what we have been doing, and that is to try to make our company as strong as it can be and our employees as healthy as they can be.

Mr. HUDSON. Great. Well, I thank the panel and, Mr. Chairman, I yield back.

Chairman ROE. I thank the gentleman for yielding, and I certainly want to thank our witnesses for taking your time today. It has been fantastic. And I also want to thank all the people here in the audience who came in. As you can see, this is incredibly complicated, and we have only been two hours. We have only begun to scratch the surface of how complex our health care system is.

By the way, I want to mention one thing. I think when the Lord walks on this earth again, it will start at St. Jude's Children's Hospital. I was a medical student there in 1969. My first rotation, pediatric rotation, was St. Jude's Children's Hospital. At that point in time, 90 percent of those children died, 90 percent. Today, 90 percent of those children live. It is absolutely unbelievable. And every child is treated for free. Every child's family is flown there for free. I probably will get a little bit emotional talking about this.

My partner's child, my partner in medical practice, his wife was in the hospital having a baby when his 3-year-old child had a seizure and found out that he had a metastatic tumor from the abdomen with a 98 percent mortality. He was 3 years old. That boy graduates from high school this year. It is an amazing story. I hope that this health care plan, or whatever you want to call it here, doesn't interrupt the incredible medical innovations that we have in this nation.

Yesterday on the airplane flying over here to Charlotte from the Tri-Cities, I ran into a constituent of mine who was going to the M.D. Anderson Hospital. He had a familial leukemia that had a 4-month survival rate 12 years ago. We don't want to stop that in this nation. We want to continue to be the country that provides that medical research and doctors that provide the kind of care that we are getting that is available nowhere else in the world.

I will now yield to my good friend, Mr. Hudson, for his closing remarks.

Mr. HUDSON. Thank you, Mr. Chairman. Again, thank you for being here today, bringing this hearing to Concord and Cabarrus County. This has been extremely informative to me, and I thank our witnesses from both panels for sharing your testimony.

I think we all share the goal of having the best health care in the world here in this country, having it accessible to everyone, and having it at a price people can afford. My desire is that individuals have more power and more control over the decisions when it comes to health care. A lot of you may have seen Dr. Ben Carson when he spoke at the Prayer Breakfast recently. I thought he put it so well when he said if it was up to him, every child who is born in this country, he would hand them a birth certificate and a health savings account. And if they couldn't afford to put money in their health savings account, then the Federal Government would put it in for them because it would be cheaper than a lot of the social welfare programs we do now.

And by putting the power in that individual's hands to make health care decisions, if you combine that with some commonsense things like liability reform, like more transparency in costs, allowing insurance companies to compete across state lines, tax credits for folks who buy their own insurance, if you bring these market-based reforms into health care and empower individuals to make decisions, individuals will make smarter decisions. They will make smarter decisions about what kind of preventive care they seek. They will make smarter decisions about what kind of tests that they and their doctors decide they might need or that a family member might need, and we will continue to have the best quality health care in the world.

There is a reason people come here for health care from other parts of the world. It is because we have the best quality. So I want to see us move toward more access, more affordability, but keep that quality of care. I am just really afraid that the program we are moving towards, the Affordable Care Act, is going to destroy the quality and the access in an attempt to fix the price.

And then the other side effect that we have talked about a lot today here is the impact on our businesses, businesses who are trying to do the right thing, to provide health care, to even provide preventive care. I have heard some remarkable stories here today. But this law is going to become such a burden to these businesses. Not only can they not afford to do what they are doing to take care of their employees, but I question whether they can keep their doors open and keep the jobs that we need so desperately in our communities.

And so I appreciate the testimony, I appreciate the opportunity to highlight these issues, and I just pledge to you that I will continue to work as hard as I can to make improvements to this law as long as this law is the law of the land and look for alternatives to this law as we build support to do that.

So, with that, Mr. Chairman, with much gratitude to you for being here, I yield back to you, sir.

Chairman ROE. I thank the gentleman for yielding, and I want to thank the panel and the audience. You have been great out there.

And if he is not going to do it, if Mr. Hudson is not going to do it, I am going to introduce his mother, who is here in the audience today—

[Laughter.]

Chairman ROE [continuing]. And thank her for being here, because without you, he wouldn't be here. So, thank you for that.

I was out at a VA jogging many years ago when this veteran stopped me and he said, Doc, he said, do you know what the problem with this place is? And I said no. And he said, alcohol, tobacco, and inertia. And I think that is what basically, Mr. Bass, you said was the problem we have, is that people need to get up and move and not smoke and drink too much, and that probably would take care of their own health.

To give you an example of a wellness program, the government had absolutely nothing to do with this. It is called BAE. BAE is a large, worldwide corporation, and they make in my district C-4. If it blows up in Afghanistan, we made it in Kingsport, Tennessee. When the helicopter blew up inside the bin Laden compound, I know where the C-4 came from.

They started a prevention program about six years ago where if you were an obese, diabetic, smoking, hypertensive train wreck waiting to happen, you could do that, but you were going to be an expensive train wreck and it was going to cost you. But if you got your hemoglobin A1C down, you quit smoking, you got on the wellness program, they would pay you. So they reversed the incentives. Doctors have been incentivized to take care of sick people instead of incentivized to make people well. So what they did was they had put this program in, and all of their 700 employees, every single one of them participated in this program, and in six years, even with these huge rate increases—they are self-insured—they have had one minimal rate increase in six years. It is amazing. That should be done around the country.

I personally use a health savings account, as Mr. Hudson said. I am a very savvy consumer of health care. I negotiate. I went into the outpatient clinic not long ago for a procedure. I had to have a minor procedure. So I negotiated the price, because they got their money in a millisecond. I didn't ask the insurance company. I asked my doctor. I knew I needed it. I went in and got it done. I got a 35 percent discount. My son worked for the hospital medical system. He said, dad, you could have gotten a 50. I wasn't as good a negotiator as I thought. [Laughter.]

But anyway, I think we have learned a lot today, and I want to thank the host here at the college for allowing us to be here and sharing this facility, and all of you all for coming. I have learned a lot. You can see just how we have just scratched one part. We haven't even talked about Medicare, which I am passionate about. I have a bill out there that I am the primary sponsor of, and Mr. Hudson is a co-sponsor of this bill, to repeal the IPAB. It is the worst piece of the entire health care bill, and it is going to drastically affect our senior citizens in a negative way. It will ultimately ration their care.

So I am going to continue to work on this as long as I am allowed to serve in the Congress of the United States, and certainly his door is open, my door is open. I have learned more at these hearings out here in the field than I do back in D.C., and I want to thank you all for being here, all eight of you.

And without any further comments, this hearing is adjourned.  
[Whereupon, at 11:00 a.m., the subcommittee was adjourned.]



